DOCUMENT RESUME

ED 259 251 CG 018 352

TITLE	Current Status of Drug Abuse Prevention and Treatment. Hearing before the Subcommittee on Crime of the Committee on the Judiciary. House of Representatives, Ninety-Eighth Congress, First Session (September 22, 1983).
INSTITUTION	Congress of the U.S., Washington, D.C. House Committee on the Judiciary.
PUB DATE	85
NOTE	238p.; Some pages are marginally reproducible due to small print.
PUB TYPE	Legal/Legislative/Regulatory Materials (090)
EDRS PRICE	MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS	*Drug Abuse; *Drug Rehabilitation; *Federal Aid; *Financial Support; Hearings; *Prevention; *State Programs
IDENTIFIERS	Congress 98th

ABSTRACT

This document contains transcripts of witness testimony, prepared statements, and supplemental materials from the Congressional hearing called to examine the current status of drug abuse prevention and treatment programs in the United States. Witnesses include Dr. Edward N. Brandt, the assistant secretary for health of the United States Department of Health and Human Services, and Dr. William Pollin, director of the National Institute of Drug Abuse, who outline the current extent of the drug problem, some of its negative consequences, and the role the Department of Health and Human Services is playing in combating the problem; two former drug addicts who discuss their experiences; and two panels of witnesses. The first panel consists of Thomas Kirkpatick, Jr., the executive director of the Illinois Dangerous Drugs Commission; John Gustafson, the deputy director of the Division of Substance Abuse Services for New York state; and Richard Russo, the assistant commissioner of health for the state of New Jersey. The second panel consists of Dr. Anderson Johnson, the director of the Health Behavior Research Institute; Sue Rusche, the executive director of Families in Action in Atlanta, Georgia; and Dr. Mel J. Riddile, the director of Straight, Inc. for greater Washington. Appendices contain the 1982 National Household Survey on Drug Abuse, selected articles on drug abuse, and an outline for Narcotics Anonymous groups. (NRB)

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ED259251

CURRENT STATUS OF DRUG ABUSE PREVENTION AND TREATMENT

HEARING

BEFORE THE

SUBCOMMITTEE ON CRIME

OF THE

COMMITTEE ON THE JUDICIARY
HOUSE OF REPRESENTATIVES

NINETY-EIGHTH CONGRESS

FIRST SESSION

ON

CURRENT STATUS OF DRUG PREVENTION AND TREATMENT

SEPTEMBER 22, 1983

Serial No. 142

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CONTENTS

WITNESSES

Page
Brandt, Edward N., Assistant Secretary for Health, U.S. Department of Health and Human Services 3
  Prepared statement 18
Dean, former drug addict 49
Gustafson, John, deputy director, division of substance abuse services, State of New York 66
  Prepared statement 93
Johnson, Dr. C. Anderson, director, Health Behavior Research Institute, University of Southern California 107
  Prepared statement 112
Kirkpatrick, Thomas, Jr., executive director, Illinois Dangerous Drugs Commission, and president, National Association of State Alcohol and Drug Abuse Directors 66
  Prepared statement 67
Paula, former drug addict 49
Riddile, Dr. Mel J., director, Straight, Inc., Greater Washington 107
  Prepared statement 138
Rusche, Sue, executive director, Families in Action, Atlanta, GA, and secretary, National Federation of Parents for Drug Free Youth 107
  Prepared statement 130
Russo, Richard, assistant commissioner, New Jersey Department of Health 66
  Prepared statement 85

APPENDIX

National Household Survey on Drug Abuse, 1982 147
Selected Articles on Drug Abuse 152
Outline for Narcotics Anonymous Groups 232

CURRENT STATUS OF DRUG ABUSE PREVENTION AND TREATMENT

THURSDAY, SEPTEMBER 22, 1983

House of Representatives,
Subcommittee on Crime
of the Committee on the Judiciary,
Washington, DC.

The subcommittee met, pursuant to call, at 10 a.m. in room 2237, Rayburn House Office Building, Hon. William J. Hughes (chairman of the subcommittee) presiding.

Present: Representatives Hughes, Schumer, Sawyer, Sensenbrenner, and Shaw.

Staff present: Hayden W. Gregory, counsel; Edward O'Connell, and Eric E. Sterling, assistant counsel; Charlene Vanlier, associate counsel; and Phyllis N. Henderson, clerical staff.

Mr. Hughes. The Subcommittee on Crime will come to order.

The Chair has received a request to cover this hearing in whole or in part by television broadcast, radio broadcast, still photography or by other similar methods.

In accordance with committee rule 5(a), permission will be granted unless there is objection.

Is there objection? Hearing none, permission is granted.

This morning, the Subcommittee on Crime is beginning an examination of the status of our Nation's drug abuse prevention and treatment programs. In the last Congress, we held several hearings on the relationship between drug abuse and crime.

Dr. John Ball of Temple University Medical School explained his famous study of the criminal history of addicts from Baltimore. It is worth repeating his conclusion here that an addict in treatment commits only one-sixth the number of crimes as does an addict untreated and on the streets using heroin.

This subcommittee has long supported the use of drug treatment to reduce the crime rate. Before we as a society will be able to get a handle on our crime problem, we must get a firm grip on our drug problem.

Just 1 month ago, Hal Sawyer and I returned from a factfinding mission to the five South American countries that supply 35 percent of our Nation's heroin, 100 percent of the cocaine, and roughly 85 percent of the marijuana. As we talked with political leaders, physicians, law enforcement officers, and other leading citizens of those nations, they continually made the point that the drugs being grown, processed, and sold in their country were destined to supply a demand in this country.

Obviously, they were correct. We have an enormous demand for drugs here and our efforts to reduce that demand, to prevent drug abuse, must be as strong as the effort we expect from our South American neighbors.

Before I went to South America, I tended to believe that drug crop eradication and a strong enforcement effort in the source countries is the most cost-effective way to control the supply of drugs. What I saw in South America, however, was really depressing.

There are countries there in which the government does not have complete control of its territory; countries in which the patterns of corruption are deeply engrained in their society; and even countries in which the government's continued existence is indeed in question. And, of course, some countries just don't have the money for these programs.

In this situation, the ability to control the supply of drugs is very difficult if not next to nothing. Such a situation requires us to refocus on what we are doing here in the United States.

We spent a great deal of money over the last 15 years on drug abuse treatment, on research and on prevention. What have we learned about what is effective? What can we now do to effectively prevent drug abuse among our children, among our colleagues at work and our neighbors throughout the community? What have we done, as the supply of drugs has increased and struck down more people, to make treatment available to those who really need it?

One fact is significant. We've cut back in providing Federal assistance to drug abuse prevention and treatment programs. Now we must evaluate the effect of these cutbacks. This morning we want to look at all these issues.

The Crime Subcommittee has spent several years working on improving our drug enforcement abilities. My colleagues and I are proud of the role that we've played in giving law enforcement officers the tools that they need. We've modernized the law which severely limited military assistance to civilian law enforcement. Now the military can share its equipment and send drug-related intelligence obtained by the armed forces into the battle against drug smugglers.

Last week, the Subcommittee on Crime sent to the full House Judiciary Committee a bill to strengthen the coordination and direction of the entire Federal effort against drug abuse and drug trafficking. We expect to take that bill up on October 4. Our bill would provide for a Cabinet-level director to review the budgets of drug abuse-related Federal agencies and promulgate a comprehensive strategy of prevention, treatment, and enforcement.

There is no other way that we can succeed with one element and without the others. We must fight drug traffickers across the board. We must fight them in the jungles in South America and on the high seas. We must fight them at the airports and on our streets. We must fight them in the marketplace.

Ultimately, we can only eliminate their ability to sell drugs by eliminating the demand for drugs. This can only be accomplished by education and prevention programs, through the efforts of parents, of businesses and other private-sector groups, working in conjunction with the Government.

This morning, we want to see how far along we are in this fight to prevent drug abuse. We want to see how far along we are in freeing those who have become ensnared in drugs so that they can become healthy, contributing members of our society once again, and so that their families can turn their living energies to more rewarding things.

We are delighted to have with us this morning as our first witness, Dr. Edward N. Brandt, the Assistant Secretary for Health at the U.S. Department of Health and Human Services; and Dr. William Pollin, the Director of the National Institute of Drug Abuse.

Dr. Brandt directs the activities of the Public Health Service, which includes the Alcohol, Drug Abuse, and Mental Health Administration, the Centers for Disease Control, the Food and Drug Administration, and the National Institutes of Health. Dr. Brandt was confirmed by the Senate in May 1981.

Dr. Brandt is a physician by profession. Prior to joining Health and Human Services, he was vice chancellor for health affairs for the University of Texas. He served as dean of the graduate school, dean of medicine, and executive dean of the University of Texas Medical Branch in Galveston.

Currently he serves on the executive board of the World Health Organization and as the U.S. delegate to the Pan American Health Organization.

Dr. William Pollin has served as a director of NIDA since 1979. Prior to his appointment, he was the director of research at NIDA for some 5 years. He's a physician and a psychiatrist. He has extensive clinical experience as a research psychiatrist and as an evaluator of research in mental health issues. Dr. Pollin is engaged in extensive work in drug abuse prevention.

Gentlemen, we have your statements which, without objection, will be made a part of the record; and we hope that you will proceed as you see fit.

Welcome.

TESTIMONY OF EDWARD N. BRANDT, ASSISTANT SECRETARY FOR HEALTH, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY WILLIAM POLLIN, DIRECTOR, NATIONAL INSTITUTE ON DRUG ABUSE

Dr. **Brandt**. Thank you very much, Mr. Chairman.

I am Dr. Edward Brandt, Assistant Secretary for Health. As you pointed out, to my right is Dr. William Pollin, Director of the National Institute on Drug Abuse, of the Alcohol, Drug Abuse, and Mental Health Administration.

I'd like to summarize my statement and also to augment it by some visual material, Mr. Chairman. The point of my testimony is to outline the current extent of the drug problem and some of its negative consequences and the role the Department of Health and Human Services is playing in combating this problem.

Drug abuse is clearly a major public health problem. It is one, however, with unique characteristics. In the first place, drug use patterns change with great rapidity. Second, there are illegal and highly profitable activities undertaken worldwide to actively promote drug abuse.

In combating this program, therefore, the Federal Government has two objectives: First is a reduction in the supply of drugs, and second is a reduction in the demand for drug. The role of our Department is primarily in demand reduction.

Recent data from two important surveys, the 1982 high school senior survey and the 1982 national household survey, indicate that our efforts are indeed beginning to bear fruit. The person who conducted these surveys, Dr. Lloyd Johnson of the University of Michigan, is scheduled to be here today and I understand will be on one of the later panels.

By and large, the 1982 national household survey shows some moderation of the upward trends in drug use charted by earlier surveys of the 1970's. The high school senior survey also shows that American young people are continuing to moderate their use of illicit drugs.

Possible exceptions, however, to this overall picture of declining use occurred for three of the less frequently used classes of drugs: heroin, opiates other than heroin, and inhalants; none of which showed any appreciable change in 1982.

Marijuana use has shown a pattern of consistent decline since 1979. Of perhaps more significance, daily use of marijuana has decreased significantly.

The two legal drugs that are most commonly used, alcohol and tobacco, have remained at high levels. Nearly all young people have used alcohol by the end of their senior year and the great majority in the prior month. Similarly, about 35 percent of high school students smoke cigarettes on a regular basis.

Despite the generally good news about the direction in which things are moving, the drug abuse problem among Americans, and particularly among American youth, is far from being solved. For example, it is still true that roughly two-thirds of all American young people try an illicit drug before they finish high school.

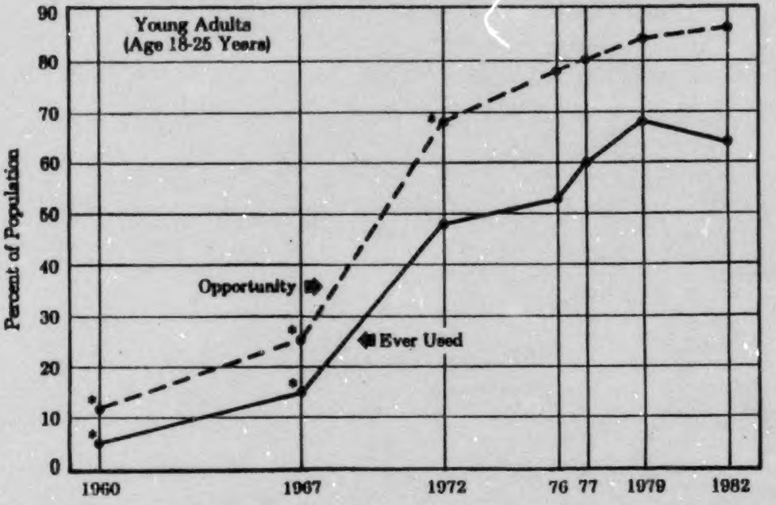
At least 1 in every 16 high school seniors is actively smoking marijuana on a daily or near-daily basis and 20 percent have done so for at least a month at some time in their lives.

About 1 in 16 high school seniors is drinking alcohol daily and 41 percent have had 5 or more drinks in a row at least once in the past 2 weeks. One-third of the American household population over age 12 have used marijuana, cocaine, heroin, or other psychoactive drugs for nonmedical purposes at some time during their lives.

Some 30 percent of high school seniors have smoked cigarettes in the prior month, a substantial proportion of whom are daily smokers. If I could direct this committee's attention, Mr. Chairman, to this easel, I think we can illustrate some of these results.

[Chart.]

Opportunity to Try Marijuana and Lifetime Experience, Young Adults: 1982



*"Projection" based on reconstructed data.

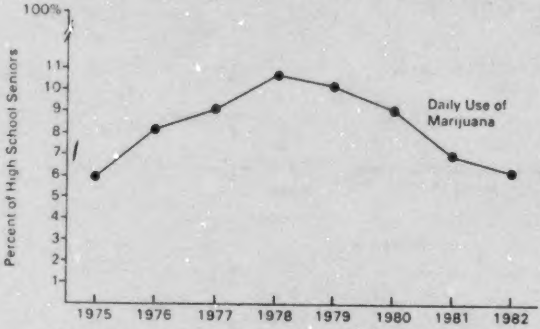
Source: National Institute on Drug Abuse, data from National Household Survey on Drug Abuse

Dr. BRANDT. The first chart shows on the orange line the opportunity to use marijuana; that is, basically the supply of marijuana, from 1960 through 1982, and the green line indicates the percentage of young adults, ages 18 to 25, and whether or not they've ever used it. You will notice that those two lines have been parallel until basically the last 3 years, where we see a decline in the utilization with a continuing increasing supply of marijuana available to them.

Dr. BRANDT. If we could look at the next one——

[Chart.]

Daily Marijuana Use, U.S. High School Seniors, 1975-1982

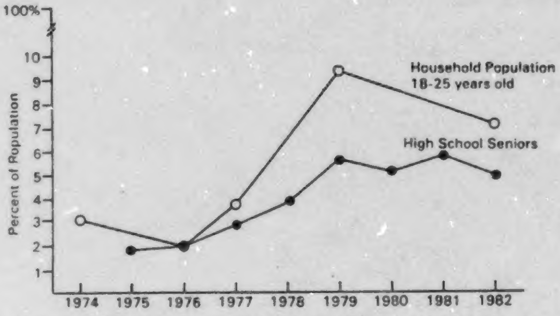


Source National Institute on Drug Abuse, data from *Student Drug Use in America*, 1982

Dr. BRANDT. The next one is a chart of the daily use of marijuana by U.S. high school seniors from 1975 to 1982. You will notice from 1978, there has been a steady decline, particularly accelerating since 1980, in the number of seniors, or percent of seniors who, in fact, engage in the daily use of marijuana.

[Chart.]

Current Cocaine Use, U.S. Household Population and High School Seniors, 1974-1982

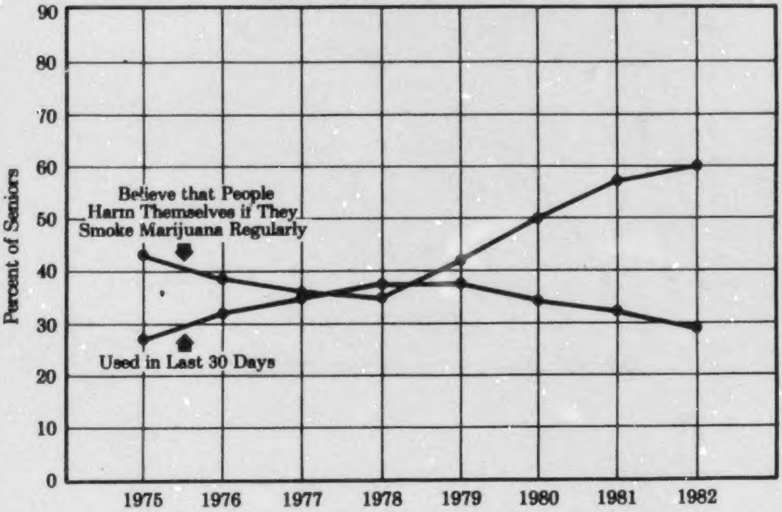


Source National Institute on Drug Abuse, data from the *National Survey on Drug Abuse* and *Student Drug Use in America*, 1982

Dr. **Brandt**. The next graph shows the current cocaine use of U.S. household population and high school seniors surveyed from 1974 to 1982. You will note that there is some moderation of cocaine use among the high school seniors, but basically not a very sharp decline, sort of a leveling off from about 1979 to the present time, with some decline in the household population of 18 to 25 years since 1979.

[Chart.]

Trends in Marijuana Use and Perceived Harmfulness Among High School Seniors: 1975-1982



Source: National Institute on Drug Abuse, data from the Monitoring the Future study, 1982.

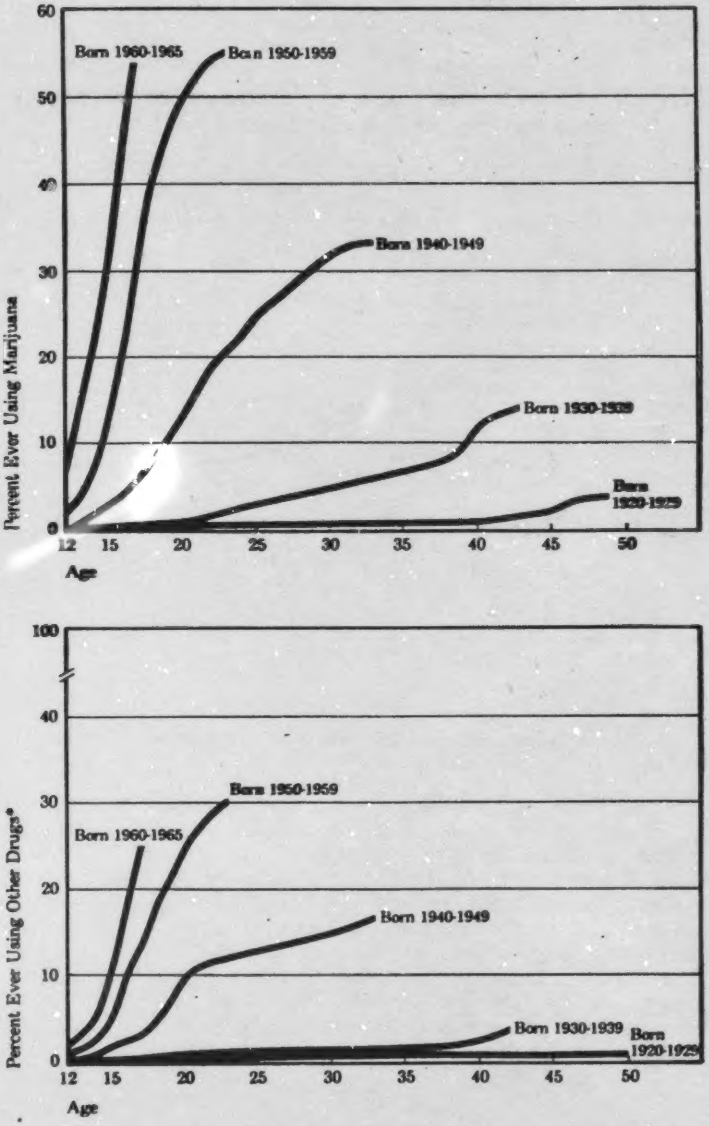
Dr. **Brandt**. Finally, one of the more encouraging graphs which shows the perception among high school seniors of the harmfulness of marijuana. From 1975 to 1982, the orange line depicts the percentage of those that believe that people harm themselves if they smoke marijuana regularly, and you will notice since 1978, a very sharp increase from roughly 35 to about 60 percent of high school seniors who now perceive marijuana to be harmful.

Accompanying that same increase in awareness is, of course, the decrease in utilization that we had noticed. This is the percent of seniors who have used marijuana in the last 30 days, not necessarily daily use, so it's even, I think, more encouraging than the earlier one.

[Chart.]

Figure 13

Lifetime Experience with Marijuana and Other Drugs for Selected Birth Cohorts



* Includes non-medical Rx, cocaine, hallucinogens, heroin

Dr. **Brandt**. Finally, I think the influence of age has—or at least, time of birth—is best demonstrated if you look at the white line at the top of this chart—this has to do with lifetime experience with marijuana and other drugs for selected birth cohorts—that cohort is the group born in the 1920's. The next one, the 1930's; 1940's and up to the 1960's. You can see sharp differences in the lifetime experience with illicit drugs, depending upon age and depending upon time at which they were born.

So it is, as you can see, a problem that has been increasing with the later births, therefore, with the younger people. The top one is for marijuana and the bottom one, other psychoactive drugs being used for nonmedical purposes.

Drug use by our young people is still believed to be the highest of any industrialized country in the world. Recent studies funded by our Department have clearly documented and quantified a relationship between drug abuse and crime, an area, of course, of special interest to this committee.

These studies, however, have also documented how effective treatment is at reducing the criminal activity associated with drug abuse.

In addition to utilization, information on current acute negative consequences of drug use, such as drug overdoses, is gathered by the Department through the National Institute on Drug Abuse's Drug Abuse Warning Network, known as DAWN.

Through the DAWN system, some 700 emergency room and medical examiner facilities located in 26 metropolitan areas throughout the United States report data on drug-related cases to NIDA on an ongoing basis. Current information indicates that while the rapidly increasing epidemic of drug abuse in this country during the 1960's and 1970's has finally begun to recede, the negative health consequences associated with drug use have not abated.

Turning now to a review of the problem, let me discuss the role of our Department. Since the States took over the responsibility for managing the delivery of drug abuse treatment and prevention services with the passage of the ADMH block grant program which occurred during fiscal year 1982—our role has become one primarily of national and international leadership in areas that could not reasonably or feasibly be assumed by the individual States.

Carrying out this role, the Public Health Service and NIDA is involved in four major areas of activity: research, epidemiology, prevention and communications. It is becoming increasingly clear that drug abuse is not a problem which is just social in nature. There is an important biological component involved in drug abuse and the exploration of that is a major focus of our research.

NIDA-sponsored research was responsible for the identification and isolation of opiate receptors within the central nervous system and the subsequent discovery of endogenous opiate-like substances. These findings provide the first testable hypothesis for a biological basis of addiction; namely, that addiction may be the result of disorders in the endorphin-enkephalin system which could result in the decreased production of both endorphins and enkephalins, or reduced responsivity resulting from reduced receptor sensitivity. Tests on these hypotheses are just beginning.

Much has been learned about acute and chronic effects of marijuana. Acute intoxication with marijuana interferes with many aspects of mental health functioning and poses a major impediment to classroom performance. It also has serious acute effects on perception and skilled performance, both of which are involved, of course, in driving.

Known effects of chronic marijuana use include impaired lung functioning and decreased sperm counts and sperm motility.

Of special concern are long-term developmental effects in children and adolescents who are particularly vulnerable to the drugs behavioral and psychological effects. We have continued to develop new and more effective drug abuse treatment agents. Emphasis has been placed on coordinating efforts to make naltrexone and LAAM, two promising new therapeutic drugs, more readily available.

Other research and scientific reviews have helped establish the addictive properties of nicotine. Tobacco smoking has been found to be a prototypic dependence process, having both pharmacologic and physiological effects.

Converging lines of research indicate that cigarette smoking is strongly related to the onset of marijuana smoking and subsequent use of other drugs. This finding suggests the prevention efforts targeted toward reducing young people's initiation into cigarette smoking can have long-term beneficial effects, not only in reduction of smoking and the associated risks, but also in the use of all other drugs.

Part of our research program is specifically focused on evaluating specific treatment modalities. I have here, Mr. Chairman, a copy of our most recent announcement for research grants and youth drug abuse treatment, which I would like to submit for the record, if you have no objection.

Mr. HUGHES. Without objection, it will be so received.

[The information follows:]

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

NATIONAL INSTITUTE ON DRUG ABUSE

RESEARCH GRANTS PROGRAM
CATALOGUE OF FEDERAL DOMESTIC ASSISTANCE NO. 13.279

YOUTH DRUG ABUSE TREATMENT RESEARCH GRANTS

JULY 1983

INTRODUCTION

Although it appears that there has been a decline in illicit drug use among high school seniors in recent years, drug use prevalence is still very high. It is estimated that 1 out of 16 seniors uses marijuana on a daily or near-daily basis (using 20 or more times in a 30-day period). Approximately two-thirds of American youth (64 percent) experiment with an illicit drug before they finish high school (Johnston et al. 1983). Multiple drug use, or harmful use of a number of illicit and licit substances in sequence and/or in combination is acknowledged to be a growing adolescent problem (Friedman 1982).

Extensive literature now exists on the nature and extent of adolescent drug use, yet there is little information about the problems that bring youth to the attention of treatment agencies, the services available to these youth and the effectiveness of these treatment efforts. Based on 1981 data collected from treatment programs and hospital emergency rooms, the National Institute on Drug Abuse (NIDA) projected that 43,000 youngsters under 18 years of age received drug abuse treatment in hospital emergency rooms and 68,000 in drug abuse treatment programs (National Drug Abuse Treatment Utilization Survey).

BACKGROUND

While there have been numerous evaluation studies of drug treatment programs in recent years, there have been few systematic evaluation research studies of programs specifically oriented to serve adolescent drug abusers 12 to 19 years of age. As a result, the literature on treatment methods and approaches for young drug abusers is extremely limited.

Even the reputedly effective youth drug programs have not been able to offer proof of that effectiveness, since few youth-serving agencies have the research capacity or resources to conduct program evaluations. Consequently, there is insufficient information about the efficacy of the treatment options available to youthful drug abusers, their families, and to the community or court referral systems.

Well conceived and rigorously designed research is needed to assess the efficacy of treatment services for youthful drug abusers, and to identify those process elements which contribute to favorable outcomes.

AREAS OF INTEREST/TREATMENT RESEARCH PROPOSALS

1. Early Intervention

NIDA is encouraging investigators to evaluate the effectiveness of different early intervention and casefinding techniques that are used to reach young drug abusers and attract them into treatment. Studies of treatment populations (Client Oriented Data Acquisition Process 1981) show that clients generally began using illicit drugs at ages 13 to 16, yet, on the average, they do not enter treatment until they are much older and seem more heavily involved in drug use and criminal activities. NIDA is interested in evaluating the efficacy of early intervention programs designed to attract youth into treatment, including programs operated by school systems, family agencies, community mental health agencies, recreational programs and other youth/family service systems.

2. Problems/Needs

There is a need to investigate and determine the kinds of problems/needs presented by adolescents entering treatment for drug abuse and the resources available to them. The National Youth Polydrug Study (Farley et al. 1979) reported that youngsters entering drug treatment have multiple problems and needs. Nearly all of the study youth (N = 2,927) admitted that they were seeking help for at least one type of problem other than substance abuse and almost half stated that their substance abuse was not the primary reason for applying to the program for admission. The severity of drug abuse problems for adolescent clients was found to be significantly related to family factors: demographic characteristics of families and education levels; the disruption and dissolution of family structure; family constellation factors; and the number of problems young drug abusers perceived to be present in their families. It is expected that adolescent drug users may make use of various community resources. Study needs to be made of the resources used for particular types of drug and drug-related problems and their effectiveness in providing drug-related services and/or in making appropriate referral.

3. Controlled Program Studies

In practice, it is often difficult to achieve random assignment of clients to treatment and no treatment (control) groups. This problem derives from the fact that treatment studies are typically conducted in settings in which the needs of human beings are foremost, and the feelings--and support--of clinicians and treatment personnel are significant. Nevertheless, there is a need to understand what interventions are effective, who benefits, and how different treatment methods and approaches can be improved for all clients. In order to do this, the field demands the development of well controlled studies of programs and service delivery components that seem to offer promise in the treatment of youthful drug abusers. In situations where random assignment is impossible, investigators should use strategies designed to control, or measure the influence of, non-treatment sources of variance. Among treatment components that need to be explored are: individual and group counseling/psychotherapy, educational/vocational rehabilitative initiatives, aftercare strategies, etc.

In understanding the efficacy of treatment programs consisting of several components, it will be important to examine issues related to the contribution of the program's component parts as well as variables related to organizational climate, structure and functioning. In all such treatment studies it will be important to understand the contribution of client variables to treatment outcome.

4. Multi-Modality Comparison Studies

To attain a broad view of treatment effectiveness and formulate conclusions which will have wide application to youth drug abuse treatment, a variety of treatment modalities should be studied. In view of this need, NIDA is interested in supporting studies that investigate, across geographic boundaries, the different types of programs serving adolescent drug abusers. Through such efforts, a typology of adolescent drug treatment programs could be constructed, identifying the principal modalities serving youth and the characteristics of client populations served by each of the modalities. On the basis of this information, followup studies can be initiated evaluating the short and long-term efficacy of different treatment approaches and the contributions made to outcome by treatment and client variables. NIDA is interested in supporting studies that make use of large samples of youth programs, using some set of uniform client classification measures, along with pre- and post-treatment criterion measures which will permit comparisons across programs and client subgroups.

5. Diagnostic Tools

Research is needed on the capacity of diagnostic strategies and tools to permit the assignment of different subgroups of young drug ab(users) to appropriate therapeutic regimens. In this regard, it will be important to assess clients at admission on psychodiagnostic variables that may predict treatment response and thereby aid in directing clients to specific treatment forms. In that spirit, effort should also be made to assess the significance for treatment outcome of various strategies for sub-grouping clients, e.g., in accord with criminal justice status, different drug use patterns, etc.

APPLICATION

The Institute wishes to encourage investigators to submit research grant proposals in the areas discussed in this announcement. Applications may be submitted by nonprofit, for-profit, or public organizations.

The regular research grant application form PHS 398 (rev. 5/82) must be used in applying for these awards. State and local agencies should use form PHS 5161 (rev. 3/79). Application kits are available in university grant offices or from the Grants Management Branch, National Institute on Drug

Abuse, 5600 Fishers Lane, Room 10-25, Rockville, Maryland, 20857; telephone (301) 443-6710. The original and six copies of applications (original and two copies if form PHS 5161 is used) must be submitted to the Division of Research Grants, Westwood Building, 5333 Westbard Avenue, Bethesda, Maryland, 20205.

FURTHER INFORMATION AND CONSULTATION

Further information about the areas of interest described in this announcement may be obtained by contacting the Chief, Treatment Research Branch, Division of Clinical Research, National Institute on Drug Abuse, 5600 Fishers Lane, Room 10A-30, Rockville, Maryland, 20857; telephone (301) 443-4060. Investigators are encouraged to submit concept papers or outlines of their research to NIDA staff prior to preparing an application.

REVIEW PROCEDURES

Review procedures for applications to this program conform to peer review procedures applicable to all research grants programs sponsored by the Alcohol, Drug Abuse, and Mental Health Administration. Applications are reviewed for scientific merit by an initial peer review group; the National Advisory Council on Drug Abuse performs a second review which may be based on policy as well as scientific merit considerations. After the Council provides final recommendations, applicants are notified of the results of the review by the Director, Officer of Extramural Policy and Project Review, NIDA.

REVIEW CRITERIA

The criteria for review of applications include overall quality and scientific merit of the proposed research. Scientific merit involves considerations such as originality, feasibility, soundness of the theoretical base in relation to previous research, soundness of approach and research design, as well as the qualifications and experience of the investigators. The availability of suitable facilities to perform the proposed studies, the supportive nature of the research environment, and the appropriateness of the proposed budget are also important evaluative factors. Additional criteria applicable to intervention research include appropriate commitments from and arrangements for collaboration with treatment programs and potential replicability and generalizability of the intervention.

AWARD CRITERIA

Criteria for funding of applications are based on the scientific merit of the proposal, as determined by peer review, and relevance to national need as reflected in NIDA's research priorities and plans. The availability of funds, the overall balance of the various topic areas in the program, the potential contribution of the study to the development and refinement of drug treatment technology, and the cost effectiveness of the study also will be considered in determining which awards will be made.

ANNUAL RECEIPT AND REVIEW SCHEDULE

Receipt Dates Renewal/New	Initial Review Group	Council Meeting	Earliest Possible Start Date
Feb 1/Mar. 1	June	Sept./Oct.	December 1
June 1/July 1	October	Jan./Feb.	April 1
Oct. 1/Nov. 1	February	May	July 1

AVAILABILITY OF FUNDS

An amount up to $750,000 will be budgeted for supporting new and competing extension (renewal) grants in each of the fiscal years, 1984, 1985, and 1986.

PERIOD OF SUPPORT

Applications may request support for a period of up to 5 years. Most projects do not exceed 3 years. A competing continuation (i.e., a renewal) application may be submitted before the end of project period. A competing supplemental application may be submitted during an approved period of support to expand the scope or protocol during the project period.

FINAL PERFORMANCE REPORT REQUIREMENTS

Grantees are expected to submit to NIDA 3 copies of the final reports of their projects within 90 days of the project's termination. The final report should contain at least the following: a literature review, a clear statement of purpose and methodology, the findings of the project, an interpretation and discussion of those findings including a clear exposition of the practical implications for treatment and of the implications for further research, a description of dissemination achieved or planned, and a summary or abstract of the report. If an intervention is being evaluated, it should be clearly and completely described.

TERMS AND CONDITIONS

Grant funds may be used for expenses clearly related and necessary to carry out research projects, including both direct costs which can be specifically identified with the project, and allowable indirect costs of the institution. Research grant support is not provided to establish, add a, component to, or operate a treatment service or program. Support for research-related costs of treatment services and programs may be requested only for those particular costs and for that period of time required by the research. Such costs must be justified in terms of research objectives, methods, and design which promise to yield important generalizable knowledge and/or make a significant contribution to theoretical concepts. If such costs are requested, applicants must provide a description of other sources of support that have been explored for them. Because of limited research funds, there is a need to keep these types of costs to a minimum in research projects and, even where justified, the full amount requested may not be awarded. Funding for program implementation is limited to the costs for small treatment components that are required in order to conduct the research.

Grants must be administered in accordance with the PHS Grants Policy Statement. Title 42 of the Code of Federal Regulations, Part 52, "Grants for Research Projects," is applicable to these awards. While references to other applicable regulations may be found in the aforementioned references, special attention is called to the following regulation:

42 CFR 2 - Confidentiality of Alcohol and Drug Abuse Patient Records.

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Friedman, A.S. Adolescent drug abuse treatment programs. In: Treatment Research Notes. National Institute on Drug Abuse, Rockville, Md.: the Institute, 1982.

Farley, E.; Santo, Y; and Speck, D. Multiple drug abuse: Patterns of youth in treatment. In: Beschner, G.M. and Friedman, A.S., eds. Youth Drug Abuse, Lexington, Ky: Lexington Books, 1979.

Dr. **BRANDT**. Data from these evaluation projects replicate the findings of earlier studies that individuals show considerable improvement after treatment, including decreased drug use, decreased criminal activity, and increased productive behavior.

Both large-scale followup studies and smaller program-based evaluation efforts have established that drug abuse treatment does work. Much of our research activities have been and will continue to be targeted to families and youth and the development of drug abuse prevention and intervention models.

This prevention research focuses on the influence of family and peers in the prevention of drug abuse. We have placed high priority on the careful evaluation of a number of drug abuse prevention strategies targeted to teenagers.

The most promising include social skills training, which focuses on communication skills, and positive peer pressure techniques, which train individuals to resist the subtle pressure from peers or from the media to use cigarettes, alcohol, and marijuana.

A 5-year grant has been awarded by NIDA to implement and test a school-based prevention program to offset peer pressure through the use of positive strategies for saying no to drugs. Dr. C. Andrew Johnson, who will be testifying later today, can describe this project in greater detail.

Two new grant announcements have just been issued in the area of prevention research. The first, entitled "Drug Abuse Prevention Research Announcement," includes parent, family skills, training research, with emphasis on school-based programs to develop skills in resisting peer pressure to use drugs.

The second announcement, entitled "Family Therapy and Prevention Research Announcement," focuses specifically on the efficacy of family therapy in the treatment of adolescent drug abusers and on the prevention of drug-abusing behavior in the younger siblings of adolescent drug abusers.

The long-term policy of the Department has been and is to develop knowledge, to provide technical assistance, and information, and to rely upon the States, local communities, and voluntary organizations for provision of direct services and the majority of funding for those services.

For the past 6 years, our primary mechanism for technical assistance has been Pyramid, a nationwide resource-sharing network that puts State and local community groups in touch with resources they may need to mount effective prevention programs.

Since its inception, we have supported the parents' movement by lending technical assistance, convening workshops and conferences, and publishing a variety of materials. A publication, "Parents, Peers and Pot," was developed for parents' groups and has been the most widely requested NIDA publication.

There are now well over 3,000 organized groups working to promote an environment in which children are getting "Don't do drugs" messages from parents, schools, the media, and the community at large.

NIDA, in fiscal year 1982, awarded a contract for the production of six marijuana public service announcements. These radio and television spots will deal with the effects of marijuana on driving, learning, and family relationships.

A second contract has been awarded to develop a national drug abuse prevention campaign and that will be launched this month.

Increasing public awareness of drug abuse and its health consequences is an important goal of this administration. The First Lady, for example, has traveled throughout the country carrying vital messages about the dangers of drug abuse and ways in which we can work together to combat it.

Her activities, together with the Federal oversight and coordination provided by the White House Drug Policy Office, have given high-level visibility to the problem of drug abuse.

NIDA's National Clearinghouse for Drug Abuse Information serves as the Federal center for collection and dissemination of drug abuse information. During the past 2 years, over 7.5 million publications were distributed. An additional 1 million publications have been distributed through a national supermarket dissemination program.

We are endeavoring to stimulate the media to communicate how the problem of drug abuse negatively affects entire communities and how it can be prevented. Media messages about drug abuse are beginning to change for the better.

Drug abuse is a problem that cuts across all social, economic, and age groups and all of these deserve our attention. But in a time when it is necessary to extract maximum benefit from the Federal investment, it is extremely important that we set clear priorities.

During the next fiscal year, fiscal year 1984, ADAMHA's efforts will focus on continuing to define and implement successful model prevention and treatment strategies and to move toward a position where application of these methods can be confidently disseminated to the community level.

Developing new data systems is another priority area. Also, we will continue our technical assistance to private-sector and family-based prevention activities. Our efforts, I think, are already paying dividends as reflected, for example, in the most recent drug use trends that we reviewed earlier today. However, drug abuse remains one of our most serious public health problems.

We appreciate, Mr. Chairman, the opportunity to talk about these issues. Dr. Pollin and I will now be glad to answer any questions that you or members of the committee may have.

[The statement of Dr. Brandt follows:]

Statement by Edward N. Brandt, Jr., M.D., Assistant Secretary for Health, Department of Health and Human Services

Mr. Chairman, I appreciate your invitation to discuss the current status of drug abuse treatment and prevention efforts. Accompanying me today is Dr. William Pollin, Director of the National Institute on Drug Abuse (NIDA). This morning my testimony will outline the current extent of the drug problem, some of its negative consequences, and the role the Department is playing in combatting the problem. Many of the activities which I will discuss are being carried out by NIDA, which is part of our Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA).

Drug abuse is clearly a major public health problem, with very unique characteristics. First, drug use patterns can change with great rapidity. Over the last two decades, for example, there has been approximately a 30-fold increase in the use of marijuana by American young people. Second, there are illegal and highly profitable activities undertaken worldwide to actively promote drug abuse. In combatting this problem, therefore, the Federal government has two objectives: a reduction in the supply of drugs and a reduction in the demand for them. The role of the Department of Health and Human Services is primarily to reduce the demand for drugs through activities in research, prevention, and treatment.

Recent data from two important surveys, th 1982 High School Senior Survey and the 1982 National Household Survey on Drug Abuse indicate that our efforts are indeed beginning to bear fruit.

By and large, the 1982 National Household Survey data show some moderation of the upward trend in drug use charted by earlier surveys of the seventies. The 1982 High School Senior Survey also shows that American young people are continuing to moderate their use of illicit drugs. Between 1981 and 1982 nearly all classes of illicit drugs showed declines in current use (that is, use during the month preceding the survey), with the most appreciable drops occurring this year for marijuana, cocaine, amphetamines, and sedatives. Tranquilizer use and hallucinogen use also showed modest declines. Possible exceptions to this overall picture of declining use occurred for three of the less frequently used classes of drugs—heroin, opiates other than heroin, and inhalants—none of which showed any appreciable change in 1982.

As measured by the High School Senior Survey, marijuana use has shown a pattern of consistent decline since 1979. While the proportion of seniors having ever tried the drug has not changed much (60 percent in 1979 versus 59 percent in 1982), the percentage reporting use in the month preceding the study dropped from 37 percent in 1979 to 29 percent in 1982. Of perhaps more significance from a public health perspective, daily use of marijuana has decreased significantly. Between 1975 and 1978, daily use of marijuana among high school seniors increased from 6 to 11 percent. However the decline since 1978 has been almost as dramatic. In 1982, active daily use of marijuana was back down to approximately where it was in 1975, at 6 percent, or about one in every 16 seniors.

The two legal drugs most commonly used, alcohol and tobacco, have remained at high levels. Nearly all young people have used alcohol by the end of their senior year and the great majority have used in the prior month. Similarly about 35 percent of high school seniors smoke cigarettes on a regular basis. In sum, both of these surveys indicate that the use of many illicit drugs has declined, or is declining, significantly from the peak levels attained during the late seventies. Still, despite this generally good news about the direction in which things have been moving, the drug abuse problem among Americans, and particularly among American youth, is far from being solved. It is still true that:

Roughly two-thirds of all American young people (64 percent) try an illicit drug before they finish high school.

At least one in every sixteen high school seniors is actively smoking marijuana on a daily or near daily basis, and fully 20 percent have done so for at least a month at some time in their lives.

About one in sixteen seniors is drinking alcohol daily, and 41 percent have had five or more drinks in a row at least once in the past two weeks.

One-third of the American household population over age 12 have used marijuana, cocaine, heroin, or other psychoactive drug for nonmedical purposes at some time during their lives. In addition, approximately one in every five Americans in households surveyed have used these drugs during the past year.

Some 30 percent of high school seniors have smoked cigarettes in the prior month, a substantial proportion of whom are daily smokers.

Despite some very welcome progress in reducing drug abuse in recent years, drug use by our young people is still thought to be the highest of any industrialized country in the world. By some estimates, the total annual cost of drug abuse to society is close to or above $100 billion. Of this figure, $10 to $16 billion is attributable to the impact of drug abusers on the health care system, the law enforcement and judicial system, the employment market, and general welfare and social service systems. Another $70 to $80 billion in annual costs result from the association between drugs and crime. Recent studies funded by this Department have clearly documented and quantified the relationship between drug abuse and crime, an area of special interest to this Committee. Those studies have also documented how effective treatment is at reducing the criminal activity associated with drug abuse.

More specifically, we know that there are approximately a half million heroin addicts in the U.S. and that these individuals, when actively addicted, are each responsible for approximately 350 crimes per year. When an addict is in treatment, the number of crimes he/she commits is reduced by approximately 84 percent; that is, the addict in treatment commits only one-sixth as many crimes as the addict not in treatment. Put another way, 295 fewer crimes are committed per year by the addict in treatment. Approximately 20% of the nation's heroin addicts (100,000) are presently in treatment programs.

Information on current, acute negative health consequences of drug use, such as drug overdoses, is gathered by the Department through NIDA's Drug Abuse Warning Network (DAWN). Through the DAWN system, some 700 emergency room and medical examiner facilities located primarily in 26 metropolitan areas throughout the U.S. report data on drug-related cases to NIDA on an ongoing basis. Current information from this source indicates that while the rapidly increasing epidemic of drug use in this country during the 1960s and 1970s has finally begun to recede, the negative health consequences associated with drug use have not abated.

For example, over the past three years—from July, 1980 to June, 1983—emergency room visits related to heroin increased in many cities throughout the country. None of the metropolitan areas sampled showed a decreasing trend during this time. In recent months, the overall trend in heroin mentions has begun to show signs of leveling off in New York, has leveled off in Los Angeles, and shows signs of small decreases in Philadelphia. Only Detroit and Phoenix are still showing a strong increasing trend.

Over the same three year period, there have also been increases in emergency room visits related to cocaine in most cities. In recent months the overall cocaine trend has shown some signs of leveling, as has the trend in New York. However, the emergency room visits related to cocaine are still increasing in Detroit, Los Angeles, New Orleans, Miami, and Philadelphia.

Turning from a review of the problem, I would like to discuss the role of the Department. When the States took over the responsibility for managing the delivery of drug abuse treatment and prevention services with the passage of the Alcohol and Drug Abuse and Mental Health Services (ADMS) Block Grant Program during FY 1982, our role became one primarily of national and international leadership in areas that could not reasonably or feasibly be assumed by the individual States. In carrying out this role, the Public Health Service—and within it the National Institute on Drug Abuse (NIDA)—is involved in four major areas of activity: research, epidemiology, prevention, and communications. As set forth in recent reauthorizing legislation (PL 98-24), NIDA retains the lead role within the Federal government for the dissemination of information based on research findings concerning the nature, prevention, and treatment of drug abuse.

In this context, it is becoming increasingly clear that drug abuse is a problem which is not just social in nature. There is an important biological component involved in drug abuse, the exploration of which is a major focus of our research. NIDA-sponsored research was responsible for the identification and isolation of opiate receptors within the central nervous system and the subsequent discovery of endogenous opiate-like substances. These findings provide the first testable hypothesis for a biological basis of education; i.e., that addiction may be the result of disorders in the endorphin-enkephalin system which could result in the decreased production of endorphins and enkephalins (as in the diabetes model where the disease results from decreased production of insulin), or reduced responsivity resulting from reduced receptor sensitivity. Tests on these hypotheses are just beginning, and their findings may open new methods for the prevention and treatment of drug abuse and other health problems.

Much has also been learned about both the acute and chronic effects of marijuana use. It is now clear, for example, that acute intoxication with marijuana interferes with many aspects of mental health functioning and poses a major impediment to classroom performance. The drug also has serious acute effects on perception and skilled performance, both of which are involved in driving and a number of other tasks. In addition to the acute effects, known effects of chronic marijuana use include impaired lung functioning and decreased sperm counts and sperm motility. Preliminary evidence also suggests that marijuana may interfere with ovulation and prenatal development, may impair the body's immune response, and may have adverse effects on heart function. It has been learned that the by-products of marijuana remain in the body fat for many weeks, with consequences whose full significance is still under study. The metabolic release of these stored by-product may produce residual effects on performance after the acute reaction to the drug has worn off.

Of special concern are the long-term developmental effects in children and adolescents who are particularly vulnerable to the drug's behavorial and psychological effects. Chronic use of the drug appears to relate to symptoms characterized by loss of motivation and energy, diminished school performance, harmed parental relationships, and other behavorial disruptions of young persons. Although more research is required, recent national surveys report that 40 percent of heavy users experience some or all these symptoms.

We have continued to develop new and more effective drug abuse treatment agents. Emphasis has been placed on coordinating efforts to make naltrexone and LAAM (levo-alpha-acetyl-methadol)—two promising new therapeutic drugs for narcotic addict detoxification and treatment—more readily available. Analyses of other therapeutic agents are also being carried out and efforts are being undertaken to evaluate the utility of clonidine and related drugs (lafexidine) in drug abuse treatment.

Other research and scientific reviews have helped establish the addictive properties of nicotine. Tobacco smoking has been found to be a prototypic dependence process having both pharmacologic and psychological effects. In particular, the euphoriant effects of nicotine are strikingly similar to those of morphine and cocaine when they are taken intravenously, and nicotine has been found to be a reinforcer for animals. Converging lines of research indicate that cigarette smoking is strongly related to the onset of marijuana smoking, and subsequent use of other drugs. For example, among all teenagers in 1982, current cigarette smokers were 11 times more likely to be current marijuana users and 14 times more likely to be current users of heroin, cocaine, and/or hallucinogens, than non-smokers. This finding indicates that prevention efforts targeted toward reducing young peoples' initiation into cigarettes can have long-term beneficial effects not only in reduction of smoking, but also in the use of all other drugs.

While much of the basic drug abuse research we carry out has implications for treatment, part of our research program is specifically focused on evaluating specific treatment modalities. Last year, for example, preliminary results became available from the Treatment Outcome Prospective Study (TOPS), a longitudinal investigation of 12,000 patients in treatment at more than 50 selected federally funded drug treatment programs during 1979 to 1981. Data from TOPS replicate the findings of earlier studies that individuals show considerable improvement after treatment. Measured by the outcome criteria of decreased drug use, decreased criminal activity, and increased productive behaviors, such as employment.

Both large-scale followup studies and smaller program-based evaluation efforts have established that drug abuse treatment does work. In the future, emphasis will be placed on smaller multiple program comparisons designed to answer specific questions, such as which patients benefit most from particular types of treatment, and additional work will be carried out using controlled clinical trials, where feasible, to answer specific questions about the effectiveness of a given intervention.

In addition, many of the Alcohol, Drug Abuse, and Mental Health Administration's (ADAMHA's) research activities have been and will continue to be targeted to families and youth and the development of drug abuse prevention/intervention models. This prevention research focuses on the influence of family and peers in preventing drug abuse as well as determining the differential effectiveness of particular prevention techniques such as individual and family skills training. We are also supporting research to explore how family functioning, family life events, and changes affect patterns of adolescent substance abuse.

For the past five years, we have placed high priority on the careful evaluation of a number of drug abuse prevention strategies targeted at teenagers. These strategies are all designed to prevent, delay, and reduce the onset of drug abuse and related social problem behaviors. The most promising identified thus far include "social skills training," which focuses on communication skills, and "positive peer pressure techniques," which train youth to resist the subtle pressures from peers or from the media to use cigarettes, alcohol, and marijuana. A 5-year grant has been awarded by NIDA to implement and test a school-based prevention program to offset peer pressure through the use of positive strategies for saying "no" to drugs. Dr. C. Anderson Johnson, also testifying here today, can describe this project in greater detail.

NIDA recently held a technical review on Intervention Strategies in the Prevention of Adolescent Drug Abuse, that included an assessment and evaluation of the state of the art of prevention within the next five years. The results of that review will be disseminated to the field as soon as they are available.

In addition, two new grant announcements have just been issued in the area of prevention research. The first, entitled "Drug Abuse Prevention Research Announcement," included parent/family skills training research, and emphasis on school-based programs to develop skills in resisting peer pressure to use drugs. Although adolescents are a primary focus of NIDA's intervention research, study of other population segments that may be at risk is also encouraged in this research announcement. The second announcement, entitled "Family Therapy and Prevention Research Announcement," focuses specifically on the efficacy of family therapy in the treatment of adolescent drug abusers, and on the prevention of drug abusing behavior in the younger siblings of adolescent drug abusers.

The long-term policy of the Department has been to develop knowledge, to provide technical assistance and information, and to rely upon the States, local communities, and voluntary organizations for provision of direct services and the majority of funding for those services. For the past 6 years, our primary mechanism for technical assistance has been Pyramid, a nationwide resource sharing network that puts State and local community groups in touch with the resources they may need to mount effective prevention programs. Pyramid has assisted State governments in planning, implementing, monitoring, and evaluating prevention programs. It also has been responsive to parents groups, schools, businesses, and industry in their efforts to carry out prevention activities.

We have also promoted community resource mobilization through the national replication of Channel One, in which the public and private sectors work together to initiate alternative prevention programs for youth, through their participation in projects to benefit their local communities. Over 165 projects involving more than 80 private sector business entities are in operation in 46 States and Territories. Of these, 102 were developed in just the last two years.

Since its inception we have supported the parents movement by lending technical assistance, convening workshops and conferences, and publishing a variety of materials. "Parents, Peers and Pot" was developed for parents groups and has been the most widely requested NIDA publication. Recently we developed "Parents, Peers and Pot II: Parents in Action," a book describing the formation and experiences of selected parent groups in urban, suburban, and rural communities. In 1981, NIDA sponsored a national conference dealing with parents and drug abuse prevention. Discussion focused on community mobilization and networking, parenting skills, and other family-centered approaches to drug abuse prevention. During 1981 and 1982, NIDA also convened four regional workshops to promote collaboration between parent groups, State agencies, and prevention and treatment programs. There are now well over 3,000 organized parent groups working to promote an environment in which children are getting "don't do drugs" messages from parents, schools, the media, and the community at large. Currently NIDA is collaborating with ACTION and the National Federation of Parents to expand and enhance involvement of ethnic minority families in the parent movement for drug free youth.

In an effort to continue to keep the public, and youth in particular, aware of the health and psychological effects of marijuana, NIDA in FY 1982 awarded a contract for the production of six marijuana public service announcements. These radio and television spots will deal with the effects of marijuana on driving, learning, and family relationships. NIDA has awarded another contract, to the Advertising Council, Inc., to develop a national drug abuse prevention campaign which will be launched this month. The basic thrust of this two-pronged campaign—aimed at teenagers 12 to 14 years old and at parents—is to accelerate the downturn in the use of marijuana and extend this downturn to other drugs.

Increasing public awareness of drug abuse and its health consequences is an important goal of this Administration. The First Lady, for example, has traveled throughout the country, carrying vital messages about the dangers of drug abuse and ways in which we can work together to combat it. Her activities, together with the Federal oversight and coordination provided by the White house Drug Policy Office, have given high-level visibility to the problem of drug abuse.

NIDA's National Clearinghouse for Drug Abuse Information serves as the Federal center for collection and dissemination of drug abuse information, providing services to both lay and professional audiences. During the past two years, over 7.5 million publications were distributed in response to requests from parents, young people, community groups, treatment staff, researchers, and State officials. An additional one million publications have been distributed through a national supermarket dissemination program.

Along with the production and dissemination of drug abuse information, we are endeavoring to stimulate the media to communicate how the problem of drug abuse negatively affects entire communities and how it can be prevented. Media messages about drug abuse are beginning to change for the better. To encourage this, NIDA is collaborating with the Scott Newman Foundation on the annual Scott Newman Award. This award, first given in 1981, is presented to television programmers who broadcast TV shows that convey a strong drug prevention theme (first awarded in 1981). This effort is designed to influence, and hopefully curtail, the kinds of pro-drug messages that appear sometimes unconsciously or inexplicitly in the TV medium.

Drug abuse is a problem that cuts across all social, economic, and age groups, and all of these deserve our attention, but in a time when it is necessary to extract maximum benefit from the Federal investment, it is extremely important that we set clear priorities. During the next fiscal year (FY 1984) ADAMHA's efforts will focus on continuing to define and implement successful model prevention and treatment strategies and to move toward a position where application of these methods can be confidently disseminated to the community level. Developing new data systems to accurately and comprehensively track the utilization of drug abuse treatment programs and to describe patient-addicts in treatment is another priority area. In our efforts to combat youthful drug abuse, we will also continue our technical assistance to private sector and family based prevention activities, such as those of local parents groups. Our efforts are already paying dividends, as reflected, for example, in the most recent drug use trends I cited at the beginning of this testimony. However, drug abuse remains one of our most serious public health problems.

Thank you for the opportunity to talk about these important issues. Dr. Pollin and I would be glad to answer any questions you might have.

Mr. HUGHES. Dr. Pollin, is there anything that you would want to add?

Dr. POLLIN. I think Dr. Brandt summarized the situation exceedingly well. I just want to reinforce the point that he made that though there has been significant recent improvement with regard to reversal of a two-decade epidemic increase, that the reductions still leave us at a point of very high vulnerability and the need to maintain an emphasis and priority on the national situation is very great indeed.

Mr. HUGHES. Dr. Brandt, I spend a lot of time visiting schools. Every time I have an opportunity to visit a high school or a elementary school, I avail myself of it. I get into schools a couple times a month.

I find in my district that the young people don't have the information on just what effect marijuana has on them. You went into great length to describe what current research describes as the impact—physiological and otherwise—on youngsters or others of smoking marijuana.

What kind of a job have we done communicating to the schools the healths and other hazards of smoking marijuana?

Dr. **Brandt**. Well, I think it may best be demonstrated by the slide, Mr. Chairman, we had earlier showing that roughly 60 percent of high school seniors are aware that there are negative health consequences from smoking marijuana.

Now being aware of these, or recognizing these and taking action on it are not necessarily the same thing, as we can witness in all sorts of other behaviors that both adults and young people engage in that are known not to be healthy.

Part of our program, and as I said earlier, one of the grants recently awarded to Dr. Johnson in California will, in fact, develop techniques for better awareness of young people to the negative health effects of marijuana use and the use of other drugs.

I should also point out that another major activity of the Department has been the teen-aged drinking and driving initiative. We are pulling together we now have involvement in all 50 States—of the chapters of Students Against Driving Drunk, SADD, and attempting through peer techniques to point out to young people that anything that interferes—any drug that interferes with your ability to drive, which includes marijuana and any other psychoactive drug, and alcohol is going to lead to trouble. I think that that message is starting to get out there.

I agree there are a lot of students who aren't aware of it yet, but we certainly have efforts under way.

Dr. Pollin may wish to elaborate some.

Mr. **Hughes**. Dr. Pollin.

Dr. **Pollin**. Mr. Chairman, I think one essential point here is that we are in the midst of an ongoing process and that whereas just a few years ago only a minority of our students, as well as the general population, were concerned with the use of marijuana, that that figure continues to increase—the percentage of those who see the health risks and who have negative reactions.

I'd like to supply for the record a more recent data source, the California poll, the Field poll, which was published August 1 of this year, which indicates that even in California, which has tended to be the bellweather State and often to be first in terms of setting trends with regard to increased drug use, that marijuana use continues to drop. There continues to be an increase in the percentage of people who see it as a problem, a dangerous drug, an increase in the percentage of population who are in favor of stricter controls, stricter regulation.

So the changes which the charts have shown, we think and hope will continue in the same direction and the problem which you accurately describe, we hope, is in the process of being remedied.

California
Opinion
Index

• *A Digest on How the California Public Views a Variety of Matters Relating to:*

Marijuana

August 1983

Background

Widespread use of legal and illegal drugs has been a major feature of the last two decades' turbulent social scene. Recurring themes in today's news involve the seizing by authorities of a drug cache with a huge dollar "street value"; illicit use among famous people in the arts, sports, business world and government; and an increase in drug related crimes, accidents, disease and poor health.

However, recent studies by the National Institute on Drug Abuse have found that, despite the huge increase in availability of both illegal drugs (e.g., heroin, cocaine, marijuana) and legal drugs (e.g., tranquilizers, sleeping pills, cigarettes, alcohol), overall drug use is down.

Social scientists have theorized that a significant cultural change has taken place in the way the public views and uses drugs. Referring to the 1965-1978 period as the "drug epidemic" years, they say that the turn to drugs was part of a larger social phenomenon in which people sought present-tense personal gratification and turned away from family-based commitments.

Now the pendulum appears to be swinging back. There are signs that the public is becoming less tolerant of the excessive use of its most popular drugs — alcohol and cigarettes. For example, the legal crackdown on drunken driving may be a form of increasing social pressures on drug users to become more responsible for their actions. Another example is that cigarette smoking in public places, which was virtually unquestioned not too long ago, is increasingly being challenged by non-smokers.

Most of the discussion and debate about illegal drug use during the past twenty years has focused on marijuana. At the start of the drug era, a large majority of the public strongly supported legal steps designed to discourage the use of marijuana. However, during the 1970's, as more and more of the public began using the drug, a trend toward liberalizing marijuana laws developed.

The growth of illegal cultivation of marijuana in California, particularly in its northern counties, has introduced an economic aspect to the debate about marijuana legalization. The argument goes that if marijuana cultivation in California is so widespread and profitable (some estimates put the crop value at $1 billion or more, ranking it among the state's largest cash crops), why not tax it and obtain needed revenue?

The Field Institute, in a statewide survey completed in June of this year, updated its previous measures on statewide marijuana use and public attitudes toward marijuana laws. The survey also examines the issue of whether the growing of marijuana in this state should be permitted and taxed.

Findings in Brief

☐ **Fewer California adults say they smoke marijuana today than did so four years ago. About one in eight adults (12%) says he or she presently smokes marijuana, down from 17% who said this in 1979.**

☐ **The "ex-user" population, those who once used marijuana but have stopped, is at 31%, the highest percentage ever recorded.**

☐ **The decline in marijuana use has occurred primarily among younger adults. While more men than women currently smoke marijuana, proportions for both groups are down from previous years.**

☐ **Frequency of marijuana use among smokers has also declined since 1979. Four years ago, 29% smoked marijuana once a day or more. This year's survey finds that the number of heavy "pot" smokers has halved to 15%.**

☐ **Health concerns (51%) and a lack of interest (41%) are cited as the main reasons for not smoking marijuana by non-smokers. The fear of losing control has increased from 6% to 18% during the past four years as a reason for its non-use.**

☐ **Public attitudes toward marijuana laws have stiffened since 1979, reversing a ten-year trend toward increasing liberalization. Today, a majority (54%) favors strict enforcement of marijuana laws or the passage of even tougher laws. This is up from 36% who felt this way in 1979. Meanwhile, support for legalization has declined by ten percentage points (from 42% to 32%).**

☐ **There has been a significant decline in support for the argument that marijuana is no more dangerous than alcohol during the past four years.**

☐ **Nearly two out of three Californians (65%) agree that marijuana is a dangerous drug and can make a person lose control of what he or she is doing.**

☐ **A strong majority (64%) disagrees with the view that marijuana should be legalized so it could be taxed the same way tobacco is. Underlying this stand is the belief, expressed by 51% of the public, that legalizing the sale of marijuana would not benefit the state's economy.**

☐ **The pronounced shift away from the trend of greater acceptance of marijuana is due in part to the reactions and opinions of the growing body of ex-users. This group's attitudes are becoming more conservative in regard to viewing marijuana as a dangerous drug and believing that legal restraints should be strengthened rather then relaxed.**

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Fewer people now smoke marijuana

An eight-year series of statewide surveys shows that use of marijuana by Californians is on the decline. The proportion of those describing themselves as present marijuana smokers has dropped from 17% to 12% since 1979. Those who have tried marijuana but now classify themselves as former smokers are at an all-time high of 31%.

According to The Institute's measurements, usage of marijuana grew steadily through the late 1970's. In 1975, 28% said they had tried marijuana, with 9% saying they were current smokers. In 1979, these proportions increased to where 42% of the public had tried marijuana and 17%, or one in six, were current smokers. This year's findings indicate a leveling off in the proportion of marijuana "triers" and a decline of five percentage points in the proportion of current smokers.

Marijuana use among adults	1983	1979	1976	1975
	%	%	%	%
Have ever tried	43	42	35	28
Current smoker	12	17	13	9
Former smoker	31	25	22	19
Never used	57	58	65	72
(Base)	(763)	(498)	(1008)	(1011)

Decline most evident among younger adults

The current survey finds that the recent decline in marijuana use has occurred primarily among younger adults. In 1979, 35% of the 18 to 29 age group said they currently smoked pot. Now just 24% of respondents in this age group are smokers.

Usage is also more prevalent among men than women, although use is down for both. At present, 15% of California males say they now smoke marijuana, about twice the proportion of females who says this (8%).

	Proportion of current pot smokers	
	1983	1979
Statewide	12%	17%
18-29	24%	35%
30-39	20%	21%
40-49	3%	7%
50-59	—	—
60 or older	*	—
Male	15%	22%
Female	8%	11%

*Less than 1%

Frequency of use has also declined

In addition to the decline in the percentage of smokers, frequency of marijuana use has also declined since 1979. Four years ago, greater than one in four adults (26%) identified themselves as heavy smokers, smoking marijuana once a day or more. Another 22% could be considered light smokers, smoking less than once a week. This year's survey finds that just 15% of the current marijuana smokers are now heavy smokers, while the proportion of light marijuana smokers has nearly doubled to 38%.

Frequency of present pot use among current smokers	1983	1979
	%	%
Once a day or more	15	26
2-6 times per week	30	34
About once a week	16	19
Less than once a week	38	22
No answer	1	*
(Base)	(80)**	(85)**

*Less than 1%

**Small sample base

Health concerns, lack of interest main reasons for non-use

The most frequently mentioned reasons for not smoking marijuana among non-smokers relate to health concerns or a lack of interest. About half (51%) of those who don't smoke marijuana cite health concerns/don't smoke anything as their reason. Next most frequently mentioned is a lack of interest in using marijuana mentioned by 41% in the current survey and by 46% in 1979.

Other reasons for not smoking marijuana include: might lose control (18% this year up from 6% in 1979), fear of legal prosecution (13% up from 8% in 1979), it's an addictive drug (11% compared to 15% in 1979) and religious or moral reasons (8% down from 13% in 1979).

What are your reasons for not using marijuana?	1983	1979
	%	%
Health concerns/don't smoke anything	51	58
Not interested in it/don't care for it	41	46
Might lose control	18	6
Fear of legal prosecution	13	8
Addictive	11	15
Religious/moral reasons	8	13
Too expensive	4	6
Might be contaminated with dangerous pesticides	2	7
All other reasons	7	3
No answer	2	8
(Base)	(666)	(407)

(Adds to more than 100% due to multiple mentions.)

Stiffened attitudes toward marijuana laws

The public's attitude toward marijuana laws has stiffened since 1979, reversing a previous trend toward increased liberalization. Today a majority of the public (54%) favors strict enforcement of marijuana laws or the passage of even tougher laws, up from 36% who felt this way in 1979.

Support for outright legalization, on the other hand, has declined. About one in three (32%) now favors legislation, down from 42% who said this in 1979.

What should be done about laws pertaining to marijuana?	1983		1979		1969	
	%		%		%	
Pass new and even tougher laws	31	54	20	36	49	75
Strictly enforce present laws and penalties	23		16		26	
Keep present laws but make penalties less severe	11		16		9	
Legalize it with age and other controls	29	32	34	42	10	13
Legalize it for purchase by anyone	3		8		3	
No opinion	3		6		3	
(Base)	(763)		(498)		(1011)	

Attitudes and use relationship

Public attitudes toward marijuana laws are directly related to marijuana usage. Nearly three out of four (72%) of those who have never smoked marijuana advocate strict enforcement or even tougher laws. Opinions among current smokers are just the opposite. Three out of four current smokers (73%) support its legalization. Former smokers of marijuana divide down the middle on the issue, with 40% supporting legalization and 39% in favor of strict enforcement or tougher laws.

What should be done about laws pertaining to marijuana?	Statewide	Present smoker	Former smoker	Never used
	%	%	%	%
Strict enforcement or tougher laws	54	7	39	72
Keep present laws but make penalties less severe	11	18	18	6
Favor legalization	32	73	40	19
No opinion	3	2	3	3
(Base)	(763)	(89)	(235)	(431)

Comparing dangers of marijuana to those of alcohol

One of the arguments offered by supporters of marijuana use is that it is nor more dangerous than alcohol. In 1969, just 16% of the public subscribed to that view. During the next ten years, support for this position grew to where a 54% majority agreed. However, during the past four years, the trend has gone in the opposite direction. Now just 44% believe that marijuana poses the same dangers as alcohol.

"Use of marijuana is no more dangerous than use of alcohol"	1983	1979	1969
	%	%	%
Agree	44	54	16
Disagree	52	40	75
No opinion	4	6	9
(Base)	(763)	(498)	(1011)

Most think marijuana may lead to more dangerous drugs

Currently, a majority (58%) agrees that, while marijuana may not be more dangerous than alcohol, its use leads a person to more dangerous drugs. The proportion believing this is close to that found in 1979. However, the public is far less one-sided that it was in 1969, when 83% believed marijuana led to the use of more dangerous drugs.

"While marijuana may not be more dangerous than alcohol, its use leads a person to more dangerous drugs"	1983	1979	1969
	%	%	%
Agree	58	55	83
Disagree	39	39	12
No opinion	3	6	5
(Base)	(763)	(498)	(1011)

Marijuana can make a person lose control

Most Californians subscribe to the statement that "marijuana is a dangerous drug and can make a person lose control of what he or she is doing." Nearly two out of three (65%) agree with this view. Less than one in three adults (31%) disagrees.

Among those who have never smoked marijuana, 82% believe marijuana is dangerous and can make one lose control. On the other hand, among present smokers, just 21% feel this way. Former smokers divide 51% to 45% on the side that marijuana is a dangerous drug.

"Marijuana is a dangerous drug that can make a person lose control of what he/she is doing"	Statewide		Present smoker		Former smoker		Never used	
	%		%		%		%	
Agree strongly	46	65	9	21	29	51	63	82
Agree somewhat	19		12		22		19	
Disagree somewhat	15	31	19	79	28	45	7	12
Disagree strongly	16		60		17		5	
No opinion	4		—		4		6	
(Base)	(763)		(89)		(235)		(431)	

Public divided over whether legalizing marijuana would benefit the state's economy

The public is sharply split over whether or not legalizing marijuana would benefit the state's economy. Currently, 51% do not think that it will, with 46% taking the opposite position.

Perceptions about the impact that legalizing marijuana would have on the state's economy are related to use. Nearly all smokers (92%) and greater than six in ten former smokers (61%) believe that it would benefit the economy. On the other hand, among those who have never tried marijuana, two in three (66%) think it would not.

"Since California is an excellent place to grow marijuana commercially, legalizing the sale of marijuana would greatly benefit the state's economy"	State-wide		Present smoker		Former smoker		Never used	
	%		%		%		%	
Agree strongly	27	46	71	92	37	61	12	28
Agree somewhat	19		21		24		16	
Disagree somewhat	8	51	3	6	9	38	7	66
Disagree strongly	43		3		29		59	
No opinion	3		2		1		6	
(Base)	(763)		(89)		(235)		(431)	

Legalizing marijuana to obtain tax revenues opposed

Another position regarding marijuana legalization is rejected by a large majority. This is the view that marijuana should be legalized so it could be taxed the same way tobacco is to generate needed state tax revenues. Nearly two in three (64%) disagree with this position. About one in three (35%) supports this view.

Those who have never tried marijuana are strongest in their opposition (77% disagree), while present smokers are most supportive (72% agree). However, former smokers line up with non-users on this issue, with a majority (54%) opposed to legalizing it for tax purposes.

"Marijuana should be legalized so it could be taxed the same way tobacco is to generate needed tax moneys for the state"	State-wide		Present smoker		Former smoker		Never used	
	%		%		%		%	
Agree strongly	22	35	52	72	29	46	12	21
Agree somewhat	13		20		17		9	
Disagree somewhat	10	64	8	28	13	54	8	77
Disagree strongly	54		20		41		69	
No opinion	1		--		*		2	
(Base)	(763)		(89)		(235)		(431)	

*Less than 1%

(The June 1983 findings described in this report came from a survey based on a cross section sampling of 763 California adults by telephone. Previous survey data were obtained from other statewide surveys conducted in a comparable manner.)

The *California Opinion Index* is published by The Field Institute, a non-partisan public policy research organization. The Field Institute derives its principal continuing financial support from private organizations and state agencies which make up the Institute's Policy Research Sponsors, from colleges and universities who are members of the Academic Consortium, and from media subscribers to *The California Poll*. Officers of The Field Institute are Mervin D. Field and Peter N. Sherrill. Mark DiCamillo is Managing Editor.

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Mr. HUGHES. Aside from the contract you described which is about to be let to Dr. Johnson, what does the Federal Government do to provide leadership in this area?

I look at what's happening to the budget, for instance. We've lost ground in the last few years in this whole area at a time when there's increasing concern over substance abuse at all levels. Even though we see a decline somewhat, a leveling off in the abuse of marijuana, we see an increase in cocaine in many sectors. That's moved from a substance that the jetsetters use to the drug of choice by a lot of people, accounting, I suspect, for some of the decline in marijuana abuse.

And yet, we see a decline in the money committed, you know, to this whole area of drug abuse. What is the role of the Federal Government? What is the leadership role? What are we doing to try to provide some leadership to States, communities, school districts in implementing a program that makes sense?

Dr. BRANDT. I think we have a four-pronged attack, Mr. Chairman. One prong is search, because without understanding how these drugs work and without having the knowledge base to be able to both know how to communicate to people who are involved in the abuse of drugs, and without developing positive strategies to get people out of a drug abuse pattern once they get into it, we're in bad shape. So certainly one important effort is basic and clinical research.

Those activities have been expanded in the past 2 years in an attempt to better define these activities. The second prong is epidemiology. We need to really understand who uses drugs; what are the risk factors associated with drug use; the secondary aspects that we may get at, such as our information now about the relationship between cigarette smoking and marijuana and the fact that we now know that by intervening with the cigarette-smoking habit, we are, in fact, intervening with marijuana utilization.

The third area, of course, is technical assistance. We do have a role to play in trying to work with States and with the private sector so that information is there. Fourth is the collection of information.

All of those activities are underway and I would emphasize that I think our budgets have reflected that we are no longer actually in the service delivery activity. That is, we are not providing direct service to people with drug abuse problems, but rather we have redefined our role to include the four areas I mentioned previously. We have a number of projects underway that deal with each of the major approaches to drug abuse.

Mr. HUGHES. What are we doing to get the message into the classroom, into the schools? What kind of a leadership role are we playing there? For instance, you know, the research is extremely important. We have a research component in the area of crime; the National Institute of Justice does an excellent job and we develop a great body of research but we found in the past that it's often very difficult to get through the institution of other barriers to try to utilize that research. We developed through LEAA a number of programs that endeavored to take that into the community; to put that research to the test in the marketplace.

What are we doing at the Federal level to do that? I mean, the drug problem is a national problem. Most of this stuff isn't grown locally. I mean, we haven't done a very good job of containing it in many instances and there's a national role for us to play.

What are we doing to try to assist communities that want to do something about it?

Dr. POLLIN. Mr. Chairman, I think we can answer that question in two ways. We can inventory our activities and I would like to provide for the record the whole range of conferences, technical assistance activities, publications and the like which will, I think you will agree, add up to a really significant level of varied activities targeted at different appropriate groups.

NIDA'S PREVENTION INFORMATION DISSEMINATION AND TECHNICAL ASSISTANCE ACTIVITIES

During FY 1983, the National Institute on Drug Abuse (NIDA) provided information, technical assistance, and consultation for Federal, national, State and local organizations, as well as the general public in the area of drug abuse prevention/education. Information dissemination activities included the production and distribution of printed matter and visual materials to special audiences and the general public. These materials focused on providing accurate information about drugs and their hazards; information on prevention approaches, strategies, and information on the parents movement. Technical assistance and consultation activities consisted of the dissemination of effective prevention strategies and information designed to strengthen State and local capacities for managing prevention programs. Technical assistance functions included both on-site and off-site assistance.

NIDA's specific FY 1983 prevention/education activities include the following:

1. PREVENTION REPOSITORY

NIDA established a Prevention Repository of over 6,000 information items consisting, in part, of a computerized biographic data base, which facilitates easy and timely access to indexed information retrievable for use in response to inquiries. The hard copy items, dealing with drug abuse prevention/education/evaluation have been placed on shelves and in file folders for use as reference by NIDA staff. New materials are being added to the repository on an ongoing basis. A special effort is being made to obtain a comprehensive collection of drug abuse prevention school curricula, research papers and articles on the "Saying No" types of smoking strategies. All new materials in the computer file are being abstracted to provide easy access to information for public use. The repository is the foundation for NIDA's technical assistance functions. It is a major resource to organizations and individuals interested in both current and historical materials on prevention topics, strategies and prevention curricula.

2. TECHNICAL ASSISTANCE AND CONSULTATION

During FY 1983, NIDA has actively provided technical assistance and consultation to a large number of organizations and individuals concerned with the development and implementation of prevention/education program activities throughout the country. Major FY 1983 accomplishments include:

(1) Technical Assistance/Information Services System

In April of 1983, "800" toll-free telephone lines were installed for the purpose of receiving inquiries for technical assistance related to prevention program planning, implementation and evaluation. In April, May and June, the availability of the "800" line was announced to specified groups in the prevention/education fields. The number of mail and telephone inquiries received by the Prevention Branch has increased 500 percent since the technical assistance system was initiated, with most of that increase having occurred since the installation of the "800" line. It is estimated that the demand for this service will dramatically increase as information is further disseminated as to the availability of the service.

(2) National Prevention Coalition

NIDA has provided technical assistance for formation of a national prevention coalition which involves volunteer and private sector organizations. The coalition is developing long-range community prevention strategies. Participants include, but are not limited to: American Medical Association, International Lions Club, National 4-H Association, American Association of School Administrators, National Parent/Teacher Association, National Federation of Parents, Quest National Center, Association of Junior Leagues, Education Commission of the States, and Rotary International.

(3) United States Football League (USFL)

The USFL requested and received technical assistance from NIDA in establishing an employee assistance program having a major emphasis on substance abuse prevention/intervention. In March of 1983, a press conference was held to announce the program. Unique to this effort is inclusion of the families of the players in the program and the involvement in future career planning for the athletes.

(4) "The Chemical People"

NIDA has been working with WQED, a PBS radio station in Pittsburgh, Pennsylvania to provide technical assistance in a national television outreach project which was initiated by the National Center for Youth, their Families and Society, in association with the National Federation of Parents, and funding solicited from the Richard King Mellon Foundation. On two evenings, November 2 and 9, 1983, a two-part program will be broadcast over 300 PBS stations around the country. Each station has been urged to schedule a local program on a night between the two national programs. A promotion strategy campaign has been planned prior to the televised programs to be directed to youth organizations, health professionals, schools, etc. A concerted effort is being made to encourage local community involvement in dealing with the drug abuse problem among youth after the two programs have aired.

NIDA is developing, in conjunction with the State Prevention Coordinators (SPC's), materials/resources useful to communications action initiated as the result of the national viewing of "The Chemical People." NIDA has assisted in the preparation of a flyer for wide dissemination which lists the resources available to those who watch the program and are directed to contact their local PBS station for information. NIDA has also provided technical assistance to other groups such as the National Prevention Coalition, the National Federation of Parents, and the National Association of State Alcohol and Drug Abuse Directors who are actively involved in preparing for a community response to "The Chemical People" endeavor. It is anticipated that the Institute will receive a large number of requests for information and technical assistance as a result of these "Chemical People" activities.

(5) National Parent Movement

NIDA provided extensive technical assistance, materials and strategy support to further efforts of the National Federation of Parents, Parents Resources Institute on Drug Education (PRIDE), Families in Action, as well as the National Multicultural Family Network.

Consultation and technical assistance to the national parent movement has been provided by financially supporting experts to travel to local communities to develop prevention strategies. Also included was consultation with State and local governments to assist in finding resources to meet new demand from communities for prevention.

The Multicultural Family Network received consultation from NIDA on initiating a parent network to meet the unique needs of multicultural families/communities for drug abuse prevention programming. National concern and interest indicates a high need for this Network, as the existing national parent movement does not effectively meet the needs of the multicultural community.

(6) Channel One Program

NIDA has provided continuing consultation to State and local communities interested in establishing a Channel One Program for prevention alternatives. A directory of program activities is being compiled.

(7) National Technical Assistance Program (Pyramid)

Through this effort, on-site technical assistance, 410 days per year, is provided to a broad range of prevention programs, national associations, State agencies and high risks groups. In addition, special support is provided to prevention networking activities of NASADAD and other coordinating groups.

(8) Other technical assistance efforts

Teenage Health Education Modules.—NIDA provided technical assistance to the Center for Disease Control on the Teenage Health Teaching Modules dealing with smoking, drugs, and alcohol.

Preventing drug abuse in the workplace.—NIDA continues to provide information and technical assistance to business and industry in the development of prevention/intervention programs.

3. PUBLICATIONS

NIDA staff has worked on the preparation of "Parents, Peers and Pot II," an expanded description of the parent movement and drug prevention; "It Starts with People II," case studies of successful prevention programs in communities and schools; "Saying No," a summary of the prevention research on peer resistance strategies; "Prevention Resources," the last issue of a series on local and national prevention resources on relevant prevention topics; "Prevention Networks," a new series to facilitate the linking of new and existing prevention networks for more effective community-wide prevention strategies; a monograph on the societal, cultural and environmental factors that exert pressure on individuals to use and abuse drugs.

(1) Parents, Peers and Pot II; Parents in Action

This publication, a sequel to "Parents, Peers and Pot," was developed in FY 1983 and will be distributed in FY 1984 containing an expanded and updated description of the parent movement and drug prevention. The initial "Parents, Peers and Pot" describes the organization of parent groups in the Atlanta, Georgia area to specifically intervene in, or prevent, drug use by their children. Included are a case study of the parent action groups, a description of the popular drug culture, discussion of research issues surrounding marijuana and young children, and program implementation guidelines for starting parent groups and working with the schools and community. Copies are provided frequently as information in responding to technical assistance requests.

(2) It Starts With People

This publication, developed in FY 1983, is a substantial revision of the original with this title. It provides a broad overview of the history of prevention and a conceptualization of the different types of prevention strategies. Also included is a description of different types of actual prevention interventions. It will serve as a much needed primer about prevention for professionals and citizens. With the increasing numbers of parents, voluntary organizations and national associations that are providing major resources for prevention, this publication will provide information helpful to the development of prevention programs.

(3) Prevention resources

This publication, published in FY 1983, provides a listing of different organizations engaged in prevention activities and a listing of publications on prevention efforts. The publication provides a valuable resource to those groups engaged in prevention program planning and implementation functions.

(4) Prevention networks

This publication being developed in FY 1983 will provide ongoing information about the state-of-the-art in drug and alcohol prevention for diverse constituency groups, including State authorities, local prevention professionals, national professional organizations, national voluntary organizations. It will describe current and effective strategies, describe major initiatives undertaken by various groups, and will try to provide an ongoing assessment of the many activities undertaken. Due to great numbers of individuals and organizations doing prevention, it is important to provide them with current, accurate information so as to maximize their efforts, avoid duplication and increase networking between the various community prevention programs.

(5) Other publications

(a) Channel One: A Collaborative Government/Private Sector Prevention Program.—This prevention booklet, reprinted in FY 1983, describes the evolution and development of a national program that included leadership and management by the private sector, development of alternatives and other projects at the community level, and a clear step-by-step community organization approach to program devel-

opment. Different approaches to Channel One are described as well as "how to" implement a program.

(b) Preventing Drug Abuse in the Workplace.—This monograph was developed by NIDA in 1982 and distributed in FY 1983 and deals with drug abuse prevention in the workplace. The monograph was designed to assist employers, employees, managers and union officials in developing effective workplace policies and programs to prevent drug and alcohol abuse and other problems. It presents information regarding the evolution of workplace programs currently in operation as well as critical issues to consider in planning and implementing a program.

(c) Adolescent Peer Pressure: Theory, Correlates and Program Implications.—This monograph, published in 1981 and reprinted in 1983 discusses some of the myths and realities of being an adolescent in today's society and the tasks that must be successfully met and addressed. It describes and analyzes the conceptual and empirical evidence for variables associated with problem behavior in general and drug abuse in particular. Broad goals of peer programs are discussed and a typology is presented on different program categories. Essential components of planning and implementing peer-oriented programs are described.

4. CONFERENCES AND WORKSHOPS

NIDA staff participated in a variety of conference and workshops during FY 1983. These activities were directed to information dissemination, information exchange and discussion of research and planning issues critical to the development of prevention efforts.

NIDA staff participated in workshops and presentation at the annual meetings of the National Association of State Alcohol and Drug Abuse Directors (NASADAD) and the Alcohol and Drug Problems Association (ADPA).

One meeting of the Prevention Workgroup was convened in FY 1983 with planning for three more projected meetings of the group consisting of members representative of a diversity of prevention professionals and volunteers. The purpose of these meetings was to advise NIDA on state-of-the-art prevention issues and concerns. As a result of this meeting, ideas and recommendations were developed for future NIDA prevention planning activities.

Planning was accomplished for five (5) workshops to be held to assist the National Prevention Network of State Prevention Coordinators (SPC's) in the Single State Agencies to develop strategies applicable to new trends in prevention.

Two Multicultural Workgroup workshops were convened in FY 1983 to advise the NIDA on relevant issues of drug abuse prevention in the multicultural community. Results of these workshops were included in recommendations to the NIDA Multicultural Plan. Continued staff communication with the Multicultural Workgroup members in scheduled.

5. COORDINATE WITH OTHER AGENCIES

NIDA staff has worked collaboratively with NIAAA, ADAMHA, Department of Education, Department of Defense, Department of Transportation, and ACTION on areas of mutual interests. Lines of continued communication and participation in planning were the main strategies used in FY 1983 were no current cooperative agreement existed. Of particular significance was the Memorandum of Understanding between NIDA and the National Highway Traffic Safety Administration (NHTSA), U.S. Department of Transportation (DOT) signed in FY 1983. This memorandum is of particular significance since one of the 1990 alcohol and drug abuse prevention objectives involves the reduction of fatalities from motor vehicle accidents. NIDA continues to collaborate with NHTSA, DOT to develop research studies to delineate the effects of drug use on performance and traffic safety.

6. IMPLEMENTATION OF PREVENTION MEDIA CAMPAIGNS: MARIJUANA CAMPAIGN AND DRUG ABUSE PREVENTION CAMPAIGN

Both media campaigns emphasized drug abuse prevention. The Marijuana Campaign involved the development of television and radio public service announcements (PSA's) targeted to 11-13 year olds on the effects of marijuana including one PSA dealing with marijuana and driving. The Drug Abuse Prevention Media Campaign was directed toward teenagers and their parents and is concerned with resisting peer pressure as well as educating parents to get involved with drug issues. Both campaigns include the dissemination of printed material, along with the media presentations and the promotion of audience inquiry to NIDA for additional prevention-related information.

(1) Marijuana campaign: "It's a Fact . . . Pot Hurts"

The marijuana Campaign was launched in May 1983, through the Single State Agencies, to reinforce the growing perception of marijuana's health consequences.

(2) Drug abuse prevention media campaign (with the Advertising Council, Inc.)

The primary focus of this campaign is to promote abstinence among young people aged 12 to 14, and to enlist parental support in encouraging young people to resist peer pressure to do drugs. The message "Just Say No" reflects the basic themes for the programs which are being carried out through public service announcements for television and radio and through public service announcements for television and radio and through posters and print advertising. The parents' message to get involved and talk to your children about drugs promotes communication, involvement, limit-setting and other appropriate parent-child relations on the drug problem. The support materials for the project include: "Peer Pressure: It's OK to Say NO"; "Parents: What You Can Do About Drug Abuse," and six flyers on the health effects of the major drugs of abuse. The campaign was launched on September 26, 1983.

7. COMMUNICATIONS SERVICES BRANCH FILM DISTRIBUTION SERVICES

This activity is a program of free loan distribution of NIDA-sponsored films to organizations and individuals nationwide such as educational and business groups, parents organizations and other general audiences to provide information and promote drug abuse prevention.

8. EXHIBIT PROGRAM

The exhibits program is an important part of the NIDA outreach effort to keep the public aware of NIDA prevention activities and services. The program consists of the presentation of exhibits at appropriate national conferences and meetings to effectively convey to the public information on drug abuse prevention and NIDA's role and accomplishments in prevention activities.

9. NATIONAL CLEARINGHOUSE FOR DRUG ABUSE INFORMATION (NCDAI) ACTIVITIES

The Clearinghouse serves as the information center for the collection and dissemination of drug abuse information within the Federal Government. It is a major source for the reporting of drug abuse research findings. The prevention-related activities conducted by the Clearinghouse are in response to public inquiries and disseminating publications on varied aspects of drug abuse including education and prevention-related aspects of the problem.

Information dissemination activities of the Clearinghouse are highly directed to youth and prevention. For example, in FY 1983, approximately seventeen percent (17%) of the total number of inquiries received by the Clearinghouse were from students with two percent (2%) of these identified as high school students. Further, fifty-nine percent (59%) of all of the inquirers requested information for students, and of these, ten percent (10%) specifically requested information for high school students.

10. OTHER MEDIA-RELATED ACTIVITIES

FY 1983 activities included the following:

(1) National Broadcasting Co. "Don't Be A Dope" campaign

NIDA assisted the National Broadcasting Company (NBC) in developing a mass media prevention program for parents and young people. Featuring NBC television personalities in 26 public service announcements, this campaign emphasized drug-free living. "Don't Be A Dope" by doing drugs. The campaign also included a series of five minidocumentaries and a drug abuse quiz program hosted by Dr. Frank Field. NBC broadcast this program March-April 1983.

(2) Peoples Drugstores media campaign

NIDA assisted Peoples, one of the largest drugstore chains in the country, in the development of its public education program for parents, "Drug Abuse: Spot It/Stop It." Composed of six drug and alcohol flyers, print ads and radio spots, the campaign emphasizes parent action to intervene in protecting their children against drugs. The campaign is scheduled for the last week in September 1983.

(3) Scott Newman Drug Abuse Prevention Awards

This joint project, sponsored by the Scott Newman Foundation and NIDA, rewards the television community for developing drug abuse prevention themes in national television programs. NIDA provides technical assistance and direction to television writers in the development of these shows. In 1982 and 1983, six of the winning programs featured the health consequences of the drugs of abuse: "WKRP in Cincinnati: Pills" and "Quincy: Bitter Pills" (which dealt with "look-alike" drugs); NBC White Paper: Pleasure Drugs, the Great American High" (which dealt with the range of drug problems); "Cocaine: One Man's Seduction" and "Quincy: On Dying High" (which dealt with cocaine); the "Epidemic: Why Your Kid Is On Drugs" (which again covers the range of drugs and drug problems). These programs reach millions of viewers with the effects of drugs on health and well-being.

More importantly, I think, we're in a position to inventory not only levels of activity, but the consequences of those activities. It seems to me that the changes in perceptions and attitudes which the various national and State surveys all show are occurring, though they are obviously multidetermined, at least in part, can be taken as an indication of the fact that the totality of these efforts, many of them coordinated, and initiated, spearheaded at the Federal level, are having an effect.

So, in terms of bottom line is, is it working? It seems to me that with appropriate cautions and caveats, we can say that the evidence seems to suggest that it is working, though we still have a very, very long way to go.

Mr. HUGHES. I would assume from your response—I think your response sheds some light on it—we will receive for the record the information, but your response also suggests that we have no program where we provide incentives for States to attempt to adapt their own programs to incorporate a drug education program in the schools.

We do not provide any economic incentives. We do not assist the school districts, for instance, who are in many instances faced with the same budget problems as the Federal Government and the State governments are often faced with.

Dr. BRANDT. The legislation creating the Alcohol, Drug Abuse and Mental Health Services block grant, of course, required—has a requirement imposed by the Congress that 20 percent alcohol and drug abuse funds will be used in prevention activities. That money goes to the States and in some States, at least, we know that they have used those funds to get into the school systems with prevention programs.

Those kinds of direct services were intended, under the legislation, to become the responsibility of the States and the funds be made available——

Mr. HUGHES. But the States have found, I would assume, that with the cuts, the effective cuts that we accomplish in the block grant, that there's competition with mental health and other programs, and they've had to cut their programs.

Dr. BRANDT. Well, the——

Mr. HUGHES. Drug abuse has been cut; educational programs have been cut.

Dr. BRANDT. There has been a floor, however, put on the funding for drug abuse programs in that block. That is, the States are mandated to spend at least 35 percent of their alcohol and drug abuse fund for drug abuse activities, so they can't cut it out completely.

Mr. **Hughes**. I see. Thank you.

The gentleman from Michigan.

Mr. **Sawyer**. What's been the trend, if you know, on the use of so-called licit drugs diverted to the illicit market, which some people think is 60 percent of the illegal drug supply in the country?

Dr. **Pollin**. Those trends are on the whole encouraging. Many of the activities for dealing with the problem of diversion occur most effectively at the State level, and following the model set initially by Wisconsin, the AMA, NIDA, and individual State bodies are very actively involved in strengthening the procedures used both by the medical profession and by State regulatory bodies.

Over all, the drugs which have been a concern in that area, as exemplified by methaqualone, are tending to show significant decreases in terms of their DAWN mentions and other measures of medical consequences.

Mr. **Sawyer**. Do you agree with the estimates that estimate that 60 percent of all illegal drugs are basically legal drugs that are diverted into illegal channels?

Dr. **Pollin**. I'm not familiar with the source of that estimate, Mr. Sawyer; I haven't seen it, but my immediate reaction would be, no, that that is emphatically not the case.

Mr. **Sawyer**. One thing that bothers me is that we recently had a view of some of the so-called crop eradication programs and that going on in some other source countries for particular—well, in part—heroin or poppy, but primarily coca and marijuana.

I'm not persuaded that as long as we have a demand for these drugs, that the eradication of source is going to be successful. You know, we tried that with alcohol a number of years ago, and it seems to me wherever there is an available market, there's always some entrepreneurs who are going to figure out a way to supply the demand.

Do you have any agreement with that?

Dr. **Pollin**. I think the important point to be made here is that we should not let ourselves get into a discussion where it's either/or; demand reduction or supply reduction. Our view is that supply reduction, as exemplified, for example, by the figures that compare the current users of cocaine to the current users of the analogous listed drug, nicotine, suggests that there is a 90-percent reduction, which is achieved by the totality of our present supply reduction effort.

We have 5 million current cocaine users, rather than the 50 million that might be expected if the drug were as available as nicotine.

On the other hand, we think that that remaining 10 percent which supply reduction can never completely eliminate, indeed, can only be controlled, substantially reduced, or eliminated, by coordinated demand-reduction efforts. I think both of them essentially.

Mr. **Sawyer**. Well, prohibition didn't seem to do much by way of alcohol use reduction, did it?

Dr. **Pollin**. In point of fact, the levels of use and the levels of medical consequence, as measured by cirrhosis and the like, showed dramatic reductions during the period of prohibition. It turned out to be a policy which the country judged to be unacceptable in terms of other kinds of social issues, but with regard to the actual levels of reduction of use, they were substantial.

Mr. **Sawyer**. Well, the People's Republic of China has eradicated opium use, but they eradicate it by eradicating the users. That's about the only country I know of that's really cleaned up the problem. Now, obviously, that's not an acceptable method here, but it does bring into focus a bit that it's the demand that is really where, I think, you know, the major effort ought to be put because I don't think we're ever going to accomplish 100-percent interdiction by law enforcement or other prohibition, and I just think we're misplacing our emphasis myself, having now spent a little time in this field.

I was a former prosecutor so I have some view of that point of view, too, but I just think that where we're falling down is really in two areas. One is the lack of sufficient emphasis, in my opinion, of preventing the diversion of licit drugs into the illicit market, which we can do entirely within our own borders; and second, the real emphasis on education and diminution of demand.

I frankly am of the opinion, after having seen it onsite, that we're wasting an awful lot of money in the so-called crop eradication, particularly in these South American countries. The motivation just isn't there, and while they put on a pretty good dog-and-pony show for you when congressional delegations have taken a look at it, their effort is pretty much like giving somebody a toothbrush and telling them to clean the Capitol Building. That's about the way they're going about it.

Do you have any view of that?

Dr. **Brandt**. Well, I think, Mr. Sawyer, that it is clearly a balance between the two, and I think the evidence at the present time is that the demand for marijuana is, in fact, coming down, while the supply of marijuana is, in fact, going up.

We know that there was some diminution in supply and, therefore, consequences when Mexico had its spraying program several years ago. Our view is that they must go hand-in-hand. That is, that we must decrease the demand, but at the same time, we have to decrease the supply.

One aspect of decreasing the supply that has an impact on demand, of course, is price. As you decrease the supply, the price goes up. You also begin to have an impact on the demand side, too, so that we would not argue with you at all that both of them have to be controlled and we certainly look upon that as our responsibility to play a role in that.

I think, though, that to say that we should let up in any way on decreasing the supply would not be effective, either.

Mr. **Sawyer**. Thank you, I yield back, Mr. Chairman.

Mr. **Hughes**. I don't think that the gentleman from Michigan was suggesting——

Dr. **Brandt**. No, I understand.

Mr. **Hughes**. We're talking about prioritizing. We were both disheartened to learn that apparently the philosophy, at least coming out of the Department of State, and I suspect the DEA has to live with it, is that the first priority would be crop substitution and eradication. Well, that's a long-term project.

I'd rather spend more money containing in South America through better enforcement mechanisms, and keep our crop eradication and substitution programs at a modest level of funding than step up our efforts in enforcement and containment, and spend more money in this area of demand reduction and education.

I share the gentleman's beliefs in that regard.

The gentleman from New York.

Mr. **SCHUMER**. Thank you, Mr. Chairman.

Of course, as members of the Crime Subcommittee, one of the most pressing reasons we are so concerned with the drug problem is crime. My first question to you, Dr. Brandt, concerns that the statistics that connect treatment and crime decrease are quite astounding. The number I have before me is that the number of crimes an addict commits when he or she is in treatment is reduced by approximately 84 percent. My question concerns the implication of this data for prevention programs. What, in your opinion, are the reasons for this decrease? Is criminal activity reduced because former addicts are able to find work and have improved self-esteem, or is it reduced because the former addict no longer needs to support his or her habit?

Dr. **BRANDT**. Well, I think that it's probably both. The idea is that if you remove their addiction, thereby allowing them not to have to spend huge sums of money to buy heroin on the streets, that you can thereby reduce their need to commit crimes, but I think at the same time, it is important to not only get them off of the drug, but also to allow them to be rehabilitated, regain self-esteem, get jobs, all of those things.

I doubt that it's exclusively either one, but is a mixture of the two. But probably the biggest impact, I suspect early on, is the loss of the need to buy the drug.

Mr. **SCHUMER**. Next question. It's my understanding that the administration originally requested that the ADM block grant be $439 million, but you reduced it to $430 million. The first question is, is that correct? The second question is, why does the administration request much less than the authorized amount when the cost of drug abuse—$100 billion is the figure you used—to our society is astonishing?

Are extra dollars no longer costefficient?

Dr. **BRANDT**. The first part of it, I got lost on. I don't think that I cut the administration request for that block grant as a matter of fact, I'm responsible for developing that. I think the——

Mr. **SCHUMER**. So it's incorrect, then, that you reduced the ADM block grant from $439 million to $430 million?

Dr. **BRANDT**. As far as I know. I don't know where that figure comes from.

Mr. **SCHUMER**. I've just been informed that I'm correct.

Dr. **BRANDT**. You're correct, but——

Mr. **SCHUMER**. I always like to be correct.

Dr. **BRANDT**. Well. [Laughter.]

Perhaps somebody could explain it to me because I don't have those figures readily at hand.

Mr. **SCHUMER**. You need a third person. You can put your hands over your eyes; Dr. Pollin, over his ears; and someone else over his or her mouth.

The basic point is that we've authorized more money——

Dr. **Brandt**. Yes.

Mr. **Schumer** [continuing]. Than you——

Dr. **Brandt** [continuing]. Have requested, yes.

Mr. **Schumer** [continuing]. As embodied by the administration——

Dr. **Brandt**. Yes.

Mr. **Schumer** [continuing]. Chose to spend. I don't understand that.

Dr. **Brandt**. Well, I think the issue has to do with attempting to obviously gain some control over the budget in a realistic way.

Now, for example, during this period of time, not only have we permitted the States the flexibility to make decisions—by the way, as you know, in our original proposal, we would have merged the ADM activities in with the general health activities, which would have even increased the efficiency considerably in my judgment.

But at the same time, the cost of these programs has gone down. Inflation has come down markedly, from roughly 13 percent when those figures were first developed to roughly 3 percent at the present time. That certainly amounts to some increase in the ability to respond.

Mr. **Schumer**. If we spent more money, would the number of heroin addicts under treatment increase from 20 percent to a higher number?

Dr. **Pollin**. Mr. Schumer, we're both aware of how complex our system of checks and balances is and how difficult it is sometimes to figure out where the decisionmaking point is with regard to what the level of funding is.

Mr. **Schumer**. The Congress has come on pretty clearly in what it's authorized, hasn't it?

Dr. **Pollin**. Well, just to point out a figure that's relevant to the current level of activity, at the moment, the Appropriations Committee recommendation to the House with regard to funding for NIDA for fiscal year 1984 is approximately 10 percent less than the administration and the President's budget request, so that we would indeed hope that the implication in your question could be perhaps reversed in terms of the eventual House action.

Mr. **Schumer**. My bottom-line question was really not—although in a sense it was turned into that—to determine who is to blame. The question is: Could we spend more dollars cost efficiently than we spend now? Could we get more addicts off the street? Could we reduce the crime rate? Could we make a greater dent in that $100 billion by spending more money than we spend now?

I don't think you'd find any quarrel from any member of this subcommittee that we ought to be spending more money than we are.

Dr. **Brandt**. I think the answer to that question, of course, is that we probably could by having more dollars, but——

Mr. **Schumer**. I'm sorry to interrupt you and I'll let you speak in 1 minute, but I find this befuddling. On the one hand, I read your testimony to be saying we're making terrific progress. We know more about how to educate our youth; we know more about how to treat addicts; we know more about how to interdict. It sounds like a nice rosy picture and the statistics, although maybe reflecting societal causes rather than our Governmental programs, look good.

Then there's the other statistic that the remaining cost of drug addiction to our society is phenomenal, $100 billion. That's more than we spend on just about any government program. Yet, at the same time, the money's being cut back. It strikes me as an anomolous situation.

Dr. **Brandt**. Well, in the first place, let me point out that we're not in any way here to take the full credit for whatever improvement has come about because it's clearly a total societal effort that has resulted in this improvement. Without everybody contributing none of this would have happened.

Second, I don't want to paint this as an overly rosy picture, but only that I'm optimistic because the lines are not still going up. On the other hand, I think that we are talking about a balance of competing interests. I could, for example, point out to you that we can reduce costs to society in a lot of other areas as well and money is going to have to come from somewhere. So the question is, if we put money into additional funding for this program, then are we going to begin to decrease kidney transplants, treatment of cancer, et cetera, et cetera? I think that clearly the decisions have to be made ultimately by the Congress with respect to the budget. We can only propose——

Mr. **Schumer**. And the Executive.

Dr. **Brandt**. And the President, yes, but I think we can only propose what the total health activities should be that, in our judgment, represent a fair balance of all of those competing needs.

Mr. **Schumer**. It is not your view that if we spent more dollars on these programs that the overall costs to our country would decrease? In other words, would we gain back more than a dollar? To me, it's not the issue that you'd have to take the money from somewhere else at this point.

Dr. **Brandt**. But all I'm saying, sir, is that I think you can make that argument for a whole variety of activities that we're engaged in.

Mr. **Schumer**. Yes, but do you agree with the statement for——

Dr. **Brandt**. I agree with the statement that——

Mr. **Schumer**. That's what I wanted.

Dr. **Brandt**. Yes.

Mr. **Schumer**. It shouldn't be so difficult to say.

Thank you.

Mr. **Hughes**. The gentleman from Florida.

Mr. **Shaw**. Thank you, Mr. Chairman.

I wouldn't want any of the witnesses to leave here thinking that any members of this committee are in any way pointing to ourselves as the Congress as being totally consistent when we authorize at one level, appropriate at another, budget at another, and then every rule that comes in waives what we did prior to that so we can go ahead and do what we darn well please, not looking back.

So I would guess that the public is totally confused, not only at the inconsistencies within the executive branch, but the legislative branch certainly follows suit and does its part in keeping the public somewhat puzzled as to what is really going on.

I'd like to pick up on what Mr. Sawyer started talking about as to what's going on overseas with regard to crop eradication. We have had many witnesses from the State Department before us, both this committee and the Select Committee on Narcotics, to which most of these members also belong. I also have traveled into various other countries with the chairman and the gentleman from Michigan. I did not have an opportunity to go on the South American trip, which I understand was very helpful and brought about much knowledge that's going to be very important to the legislative work of this subcommittee.

However, from the traveling that I have done to other capitals, I find that we don't really seem to have the priority that is necessary for the State Department in this particular area of drug eradication. I think these other countries are paying lipservice and they're putting on the dog-and-pony shows that Mr. Sawyer referred to, but I think that's strictly cosmetic because there's no followthrough. When the congressional delegation leaves, it's business as usual and the State Department's priorities simply are not where I feel that they should be.

NBC News recently did some work on this with regard to what was happening in the Bahamas and there were some quotes from the Ambassador as to what exactly the priorities are. I think that something has to be done. I understand this isn't in your shop, and I'm not going to ask you to comment on another branch, but I think there's an awful lot to be done in the Department of State as setting the priorities that the American people would want set with regard to the attitude of this Government toward other governments who turn their heads on drug dealers and those that are actually producing the agricultural crops that are poisoning the American people.

I do have an area that I do want to ask a question. Recently, there've been a few studies come out on the use of methadone. My own hometown newspaper, the Ft. Lauderdale News and Sun Sentinel, recently has done an extensive article in this particular area.

[Series reprinted in the appendix.]

Mr. SHAW. In looking at the hearings and what-not that have been held up here on the Hill, I don't think that anything really of any great significance has been done with regard to hearings as to the use of methadone and the effect of methadone, whether it's the proper way to go or whether it's itself a dangerous drug that is almost as dangerous as heroin and should be avoided and is not a proper substitute.

Recently, there's been some deaths that have been in the paper as to attributed directly to an overdose of methadone and I know, of my own knowledge in my own district, of a suicide that would not have taken place had the individual not been under the influence of methadone.

What studies have been done and what information do we have? Where are we in this process? Is methadone still an acceptable treatment? I understand the Federal courts have turned away from it.

Would either of you gentlemen care to comment on it?

Dr. **Brandt**. Let me just give an overall statement and then I'm going to ask Dr. Pollin to give the details because he's very much more familiar with it.

We have just recently undertaken within the Public Health Service a look at the issue of methadone and methadone management of heroin addiction. We have involved both NIDA and the Food and Drug Administration, which clearly has a role to play, and our view overall is that the program is currently effective and managed well and that the allegations as to safety and that we think, are not accurate. Let me ask Dr. Pollin give you more information about the methadone activity.

Dr. **Pollin**. I would only add that we have within the past 9 months prior to the appearance of the series you referred to and in no way related to that series, conducted a very extensive review, a three-session technical review.

Dr. Brandt has stated our conclusions. I think the point needs to be made that there is probably no drug currently used by the American people from aspirin on up to the most potent anticarcinogen, where one cannot, if one chooses to, focus on the side effects, the potential health risks and adverse consequences and come up with a dramatic story or series of stories if one emphasizes only those side effects.

There is no totally innocuous drug; there is no totally innocuous substance that any of us use at any time. I think that series focused exclusively, or almost exclusively, on that one side of the coin and did not present any type of balanced picture. The author of that series was invited to review in prepublication form the roughly 750 pages of data, research reviews, and most recent clinical studies, but did not avail himself of that opportunity.

So at this point, our feeling is that methadone, like all other drugs in the current U.S. pharmacopeia does have, if misused, certain serious consequences, it does represent at this point an effective and very important part of our armamentarium in treating narcotic addiction.

Mr. **Shaw**. Is it correct that the Federal courts, though, are not using that at this point as part of their treatment?

Dr. **Pollin**. I'm not certain precisely what you're referring to when you speak of the Federal courts using it or not using it as part of their treatment. Is there a particular program?

Mr. **Shaw**. Let me supply you with the information I have on that, because I would like to have your comments because I think it is an area that the committees of Congress should be taking a close look at. I also would appreciate the information that you referred to as being made available to the author of the series that I referred to so that we might have an opportunity to——

Dr. **Pollin**. We'd be very glad to provide all of that or a summary of it as you see fit for the record or to you personally.

[The information follows:]

42

TREATMENT
RESEARCH
MONOGRAPH
SERIES

RESEARCH ON THE TREATMENT OF NARCOTIC ADDICTION

State of the Art

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DHHS Publication No. (ADM)83-1281
Printed 1983

CONTENTS

PARTICIPANTS AND CONTRIBUTORS vi

INTRODUCTION xii

PART I METHADONE MAINTENANCE AND DETOXIFICATION TREATMENT

1. Uses of Naloxone in the Diagnosis and Treatment of Heroin Addiction: Barbara A. Judson and Avram Goldstein 1
Critique: Richard Resnick 14
Discussion Summary: James R. Cooper, Fred Altman, and Kim Keeley 17

2. Methadone Dose and Duration for Maintenance Treatment: William A. Hargreaves 19
Critique: Avram Goldstein and Barbara A. Judson.. 80
Discussion Summary: James R. Cooper, Fred Altman, and Kim Keeley 92

3. Factors Modifying the Pharmacological Effectiveness of Methadone: Mary Jeanne Kreek 95
Critique: Edward Senay 115
Discussion Summary: James R. Cooper, Fred Altman, and Kim Keeley 117

4. Concomitant Use of Methadone with Other Psychoactive Drugs in the Treatment of Opiate Addicts with Other DSM-III Diagnoses: Herbert D. Kleber 119
Critique: Donald F. Klein 149
Discussion Summary: James R. Cooper, Fred Altman, and Kim Keeley 158

5. Methadone Detoxification from Illicit Opiates and Methadone Maintenance: Richard Resnick ... 160
Critique: Robert G. Newman 168
Discussion Summary: James R. Cooper, Fred Altman, and Kim Keeley 172

6. Use of Clonidine or Lofexidine to Detoxify from Methadone Maintenance or Other Opiod Dependencies: Harold M. Ginzburg 174
Critique: Herbert D. Kleber 212
Discussion Summary: James R. Cooper, Fred Altman, and Kim Keeley................... 223

7. Use of D-Propoxyphene as a Maintenance or Detoxification Agent for Opiate Addicts: Edward Senay 225
Critique: William A. Hargreaves 236
Discussion Summary: James R. Cooper, Fred Altman, and Kim Keeley 240

8. Efficacy of Maintaining or Detoxifying Opiate Addicts with the Drug of Addiction vs. the Use of Methadone as a Treatment Agent: James R. Cooper, Fred Altman, and Kim Keeley.. 242

PART II EFFECTS OF METHADONE ON OFFSPRING AND USERS

1. Disposition and Metabolism During the Perinatal Period of Methadone and Other Drugs Used in Narcotic Addiction Treatment: Hazel Szeto.... 247
Critique: Donald Perrier 265
Critique: Leon I. Mann 276
Discussion Summary: Barbara Gastel and Thomas E. Collins 285

2. Methadone: Toxicity, Genetic and Perinatal Effects: Monique C. Braude 286
Critique: David Blake 315

3. Preclinical Perinatal and Developmental Effects of Methadone: Behavioral and Biochemical Aspects: Sheldon B. Sparber 318
Critique: Theodore A. Slotkin 347
Critique: Theodore J. Cicero 360
Critique: Donald E. Hutchings 368
Critique: Ian S. Zagon 376
Discussion Summary of Chapters 2 and 3: Barbara Gastel and Thomas E. Collins 391

4. Clinical Perinatal and Development Effects of Methadone: Loretta P. Finnegan 392
Critique: Mary Jeanne Kreek 444
Discussion Summary: Barbara Gastel and Thomas E. Collins 454

5. Health Consequences Associated with the Use of Methadone: Mary Jeanne Kreek 456
Critique: Herbert D. Kleber 483
Discussion Summary: Barbara Gastel 491

PART III FACTORS AFFECTING THE OUTCOME OF METHADONE TREATMENT

Introduction: Roger Meyer 495

1. Patient Characteristics Associated with Outcome: A. Thomas McLellan 500
   Critique: Herbert D. Kleber 530
   Discussion Summary: Fred Altman and Sidney H. Schnoll 539

2. Treatment Characteristics Associated with Outcome: George E. Woody 541
   Critique: Edward Senay 565
   Discussion Summary: Fred Altman and Sidney H. Schnoll 573

3. Methadone Treatment: A Review of the Research Findings: Sharon M. Hall 575
   Critique: Edward Senay 633

4. Program Policies and Procedures Associated with Treatment Outcome: Christopher D'Amanda 637

5. Community Characteristics Associated with Treatment Outcome: J. David Hawkins 680
   Critique: Richard J. Russo 701
   Discussion Summary: Fred Altman and Sidney H. Schnoll 712

6. An Overview of Client Characteristics, Treatment Services, and During-Treatment Outcomes for Outpatient Methadone Clinics in the Treatment Outcome Prospective Study (TOPS): Robert L. Hubbard, Margaret Allison, Robert M. Bray, S. Gail Craddock, J. Valley Rachal, and Harold M. Ginzburg 714

Mr. SHAW. Thank you. I yield back.

Mr. HUGHES. I have just two brief questions. You did describe the health effects of marijuana use. Would you just briefly for us describe what current medical research suggests for the effects of cocaine use?

There is some suggestion now that we have concluded that it's addictive.

Dr. POLLIN. It is one of the most dependence-producing drugs we know of. It's one of the few drugs that when used in experimental situations where primates have a choice of either getting additional doses of the drug or getting food and water, will starve themselves to death as they continue to press lever B that gives them additional doses of cocaine.

So its dependence-producing potential, its ability when used parenterally in particular, to lead individuals to make it the central focus of all their daily activities is very profound indeed. The physiological effect, in terms of changes with regard to brain, circulation and other key physiological systems have long been known.

The important point I think that needs to be more widely recognized, and I think is beginning to be more widely recognized, is how dangerous is the risk of losing control of the drug by people who initiate what they think will be intermittent or recreational use.

Mr. HUGHES. OK. The other question I have, just briefly, Dr. Brandt, you've suggested that statistics show that marijuana use in particular, and cocaine use, is on the decline or leveling off. Dr. Johnson's going to be testifying very shortly about misrepresentations individuals polled will make because of peer pressure. The suggestion is that the data we receive really isn't accurate because the ones polled are in many instances lying to the people doing the poll.

What do you have to say about this?

Dr. BRANDT. Dr. Johnson is, I think, going to testify a little bit later today on this topic, but there's no question that any time that you gain information about people's habits that can only be verified by what they tell you, that you clearly will have instances of misrepresentation, flat lying, and distortions.

The issue that I would ask is has that pattern changed in the past 20 years? These surveys have been going on for a long time. If there has been a major change, I think one has to presuppose at some place along the line that the incidents of lying or misrepresentation changed significantly enough to bias the results from year to year. I don't know that anybody has an answer to that, but on the other hand, it's——

Mr. HUGHES. We haven't done the comprehensive surveying we've done in recent years, have we?

Dr. BRANDT. Yes, we've done the same kinds of surveys, yes. So that I think that one would have to speculate—and there may be basis for that speculation. I'm not aware of it, but it would surprise me to find that the high school seniors, let's say in 1978, in discussing drug activities would be any more truthful than those in 1982.

Now there may be evidence to the contrary, but nobody would argue, I think, that you could carry those statistics out to the third or fourth decimal point and begin to push it because clearly, in all of those activities where humans are involved, there are going to be errors of one kind or another.

Mr. **Hughes**. Thank you.

Dr. **Brandt**. Could I ask—this issue about the budget has me totally confused because according to my figures, the original administration request was $439 million in 1983, and I would like, if possible, Mr. Chairman, to get that cleared up in the record. We will supply, if it's by letter or other ways, some clarification of that.

Mr. **Hughes**. The record will remain open for that submission.

The gentleman from Michigan.

Mr. **Sawyer**. I mentioned that there were estimates that as much as 60 percent of the illegal drugs were basically legal drugs diverted into illegal channels. That statistic comes from the DAWN network, the Drug Awareness Network, where emergency room treatments—now, I don't know how accurate that might be to estimating the overall use or availability, but 6 out of 10 emergency room treatments for drug abuse problems, or overdoses or whatnot, are from licit drugs diverted into the illicit market.

Now, I don't—you probably are in a better position to make a comment on how that might be reflective of the general supply or use, but that's where the 60 percent is.

Do you have any——

Dr. **Pollin**. Mr. Sawyer, the medical room emergency room mentions and the DAWN system, as you point out, cover a particular segment of the kinds of problems that result from the abuse of drugs. They are the medical emergencies and they don't cover the much larger segment of the problem consequences of drug use which have to do with those changes in behavior and social patterns that don't lead to an abrupt, acute medical emergency. Although that figure is relevant to one segment of the kinds of problems which result from drug abuse, it can't be generalized to the much larger areas of problems which don't result in such medical emergencies.

Mr. **Sawyer**. Would the proportion be different? I mean, in other words, would there be a higher proportion of emergency-type problems with the licit drugs that are diverted?

Dr. **Pollin**. I believe so, Mr. Sawyer. The problems that we see that result from the drugs that are most widely used—cocaine is currently used by 5 million Americans—that's an illicit drug. Marijuana currently is used by somewhere between 20 and 25 million. None of the licit drugs, which are misused as a result of diversion or in other ways have levels of use that come anywhere close to those levels of prevalence of those two most widely used illicit drugs.

So though with regard to the medical emergency consequence, the figure you quote is relevant; I'm sure it doesn't apply to the much broader problems of different patterns of health and social consequences that result from the use of illicit drugs.

Mr. **Sawyer**. You say that an estimated 5 million Americans use cocaine and 20 to 25 million marijuana. Do you have any estimate on heroin?

Dr. **Pollin**. Yes; our current estimate is approximately one-half million current heroin addicts.

Mr. **Sawyer**. Thank you. I yield back, Mr. Chairman.

Mr. Hughes. Thank you very much.

Dr. Brandt. Thank you.

Mr. Hughes. The gentleman from New York.

Mr. Schumer. Yes, just a quick follow-up so maybe you can, Doctor, respond by writing.

The original administration request, as I understand it, was for $439 million. That was reduced after the jobs bill to $430 million.

Dr. Brandt. Not by us, sir, that was reduced by the——

Mr. Schumer. OMB?

Dr. Brandt. No, sir; by the House, which put $9 million into the—they took the Community Support Program out as a categorical, so you have to add those two figures together, not to come up with the total amount. In the Senate, they are merged together and, therefore, appear as the same.

So it depends upon how you look at the one figure of $9 million for the Community Support Program as to how the appropriations process dealt with that figure. In the one instance, we dealt with it in the block; they dealt with it as a separate categorical.

Mr. Schumer. I see. So your total request was $439 million and never went down from that.

Dr. Brandt. That's correct, but I'll verify—I mean, that's correct to the best of the information we have here.

Mr. Schumer. OK, if you could verify that, I'd appreciate it.

Dr. Brandt. We will.

[The information follows:]

The initial Administration budget request for 1984 for the Alcohol, Drug Abuse, and Mental Health Services Block Grant was $439 million, the same as the initial 1983 appropriated level. Subsequent to submission of the President's budget the Congress approved and the President signed, a supplemental appropriations bill (P.L. 98-8, the "Jobs bill") increasing the 1983 block grant appropriation for this program by $30 million to address anticipated needs for alcohol, drug abuse, and mental health services in areas of high unemployment. This increase was a one-time stimulus needed during a weak economic period. Block grant funds are available to States for two years, and thus unexpended 1983 funds are available for their use in 1984. Since these funds did not actually reach the States until late in the 1983 fiscal year, these funds were felt to partially offset the need for as large a 1984 appropriation request as initially proposed. The Administration reflected this reality by submitting a budget amendment in April reducing the intial request from $439 million to $430 million.

Mr. Schumer. Thank you.

Mr. Hughes. I want to thank the panel very much for their contributions.

Dr. Brandt. Thank you, sir.

Mr. Hughes. Our next panel are two young people, Dean and Paula, who have extensive problems with drugs. They used to refer to themselves as "druggies." They've asked that we not use their last names and I've agreed to that particular request.

Dean and Paula, you want to come forward. We're very happy to have you with us this morning. Have you decided which one wants to go first?

TESTIMONY OF DEAN AND PAULA, FORMER DRUG ADDICTS

Paula. My name is Paula and I'm 19. I was a former drug user. I used drugs for about 3½ years and I've been straight for about 2½.

The views that I wanted to bring out are the things that I thought about as far as help or treatment. I thought about when I was using drugs, I had gotten into drugs because of peer pressure and, you know, acceptance with school because it was so widely used.

I had an older brother who was into drugs and I really was looking up to him and I wanted his acceptance. My parents had taken him to several counselors, psychiatrists. He went to the Psychiatric Institute and school counselors and never resolved the problem because a lot of the things were "It's the family," and "It's mom and dad aren't giving you enough room to grow" and really focus on symptoms rather than the problem."

Therefore, when I got into drugs, they didn't know a solution to the problem. They knew that I was into drugs and that I needed some kind of help, but they didn't know where to go. School didn't offer that because the school—a lot of times in school, they turn their back on the drug use and they say, "Well, it's just something they're going through. They'll grow out of it." They really didn't want to, you know, get involved in the problem.

So my parents were really helpless as to, you know, what to do or where to go for help. I didn't want to look at the fact that I needed—I had a drug problem. I didn't associate the problems or my grades falling or, you know, running away from home, things that I was doing, with drugs. I didn't associate it; I just looked at all the problems that psychiatrists would tell my brother, "Well, it's your family," and I would tell myself that it was my family's problem and I can't get it in school; it's too hard for me. But I never looked at drugs as the problem.

I think, you know, a lot more parent awareness—like, my parents found out—the program that I went through as far as, you know, the treatment that I went through—they found out through a parent awareness group with a bunch of parents who'd gotten together, talked among themselves to relate to each other as far as their kids and what they were doing. That helped them out. They found out a drug treatment program that would help and they went down. That's the program that I went through and got help. Now I'm straight.

Also, with counseling, they also got together and they got into the school I used to go through and did some work in there as far as we had a smoking lounge and it was really, really easy to do drugs and get high in school all the time. They made the principals and the counselors aware of this through information we gave to our parents. They went back to the school and got the smoking area abolished and got stricter, you know, more discipline in the school, and I recommend that highly as far as help.

I was thinking earlier, I don't think there is any way that my parents could have prevented me from getting into drugs because they didn't know. They didn't know what was going on; they didn't understand the drug problem until I went into treatment.

But I think it is very hard to prevent kids from using drugs nowadays because they are so widely used. Everybody's doing it, and that was my big justification, "Well, everybody's doing it and it's not that bad."

When I first did get into drugs, it wasn't that bad, you know, I was just doing pot and alcohol every now and then and I didn't—you know, my grades weren't falling and I wasn't going down in anything, but I think if the parents and principals and counselors and everybody were aware of the problems—and signs, you know, the symptoms that start showing up—to catch it early enough in the use that it would be able to be treated and dealt with and therefore you wouldn't have as big a problem.

It took 3½ years for my parents to find something for me and during that time, I went down really, really far and I was lucky that I made it into treatment without really screwing myself up.

Dean has some views on schools and things.

Mr. HUGHES. Thank you, Paula.

Dean.

STATEMENT OF DEAN

DEAN. First of all, I'd like to thank the subcommittee for letting Paula and me present ourselves.

I don't have statistics and I don't have a formal presentation, but I do have experience, and I think that's one of the most effective things. I used drugs; I used drugs chronically when I was in my schooling, my upper grades, when I was in high school primarily.

During the time I was in school, I had one drug awareness meeting, and it was when I was in the fifth or sixth grade. They gave us somewhat of a distorted view of what drugs—the effect of what drugs did. They first gave us a magazine and it was a cartoon version of drugs and the druggie and the person that does drugs and the person that's straight. They put a smile on the person that's straight and they put crosses for eyes on the person that does drugs.

It explained the physical effects of drugs and I was scared. I was in the sixth grade at the time and it scared me.

I did not have the desire at that time to do drugs or anything and that partially did help. It did scare me, but when I did get into the upper grades of school, junior high school and high school, I saw people that were using drugs, pot primarily, alcohol, even some harder drugs, ups and downs, and they didn't seem to—I didn't view them as I did the cartoon characters that I did when I was in sixth grade.

They seemed to still have short hair; they looked fairly presentable. I questioned all the things that I saw when I was in junior high from the presentation that was given when I was younger and I thought, "Well, they don't look as screwed up as I thought they would."

I think one of the things that would have helped me when I was in junior high and high school would have been more awareness meetings on what drugs are all about. Not the physical effects because primarily I think there is a disadvantage to explaining physical effects of drugs and what drugs do to you, and not the negatives, not the high that the drug produces. It catches people's attention and for me, it got me curious.

When I heard that pot produces this type of feeling, or alcohol produces this type of feeling, I disregarded the negative effects that were talked about and I focused primarily on the positive things about it. It was exciting; it was appealing to me.

I think one thing that would have helped me tremendously would have been the emotional part, evaluating the emotional part of drug use and how it's a disease of the feelings and how it destroys the family life and things along that line. I think that would have been helpful to me.

One thing I noticed from the earlier discussion, the presentation was for all seniors. It was in the senior high school. The statistics may have gone down for the seniors in high school. When I was a senior in high school, I started becoming aware of some of the physical effects that drugs have now. Cocaine, pot, how it deteriorates the body, et cetera, and I started realizing that I was needing to grow up a little bit. My future was right around the corner. I needed to go to school.

I started backing off from drugs some when I was a senior in school. I started cutting down some on alcohol use. I started cutting down some on marijuana use. I started working harder because I realized my future was ahead of me and I got a little bit scared, so I think that statistics may have gone down for the seniors, but looking back now, when I walk into game rooms, when I'm walking in shopping malls, I see 10-, 11-, 12-, 13-year-old kids now that are getting high, and they've got the long hair, and they've got the concert t-shirts on, and they're at the point I was when I was in 9th and 10th grade. That's scary.

I think that's why it's so important, and I think it would have been so helpful for me, and more so now that drugs are so widely recognized now, to start younger in schools with awareness programs—mandatory meetings for kids from sixth grade up on drugs, not just the physical effects, but the emotional effects of what it emotionally does to individuals that use drugs.

I think that that would help tremendously and I think that, from what I have seen when I've gone back to my high school since I've been graduated, I've seen that they have cracked down tremendously in the schools with security—the parking lots are now being patrolled, the hallways are now being patrolled, and that's helped. That's good because when I was in high school, people were getting high in the parking lot, skipping class, going behind the clubhouse in P.E. and smoking pot. It was unbelievable. It was like it was almost accepted and people turn their backs rather than look at the problem in school.

I can think of countless times when my mother went to the schools and said, "Look, I think my son's got a problem. I need help controlling him," and they didn't want to listen. They didn't want to listen and they said, "It's a normal thing; he'll grow out of it." OK, I didn't grow out of it and I ended up going into a treatment program and now I'm a staff member there.

But I think that that is helpful; that schools are cracking down, but I think the awareness part of it and the emotional effects, like I said earlier, are very important. It needs to be emphasized more because I don't think there's enough of that. I think along with that, in reference to schooling, attendance—I think that's a symptom of drug use. Usually an individual, when he's a chronic skipper, is in one of the later stages of drug use, but an individual, when he first starts to skip school, is a symptom that they are into drugs.

If that can be acknowledged by the school system, and people can catch that and respond on that, then that may be helpful in stopping the individual before he gets further into drugs, which may be doing an evaluation on the individual and seeing if maybe they should go into a youth awareness program or something.

I think one thing also is that people are very unaware of the programs that are in the area. At least I was. I didn't know there was any drug rehabilitation centers. I didn't know where there were AA meetings; I didn't know where there were NA meetings—Narcotics Anonymous—or whatever. Even if I did, I may not have attended one when I was using drugs, but I will say this. It might have caught my attention. I might have, at a time of need when I didn't have pressure from my friends and I didn't feel the need of peer acceptance, I might have gone and seeked out some kind of help when I was maybe at a low in my life.

But I didn't have any awareness of where the programs were in the area. I think that's important also, you know, letting people know that "Hey, there are facilities. Here's where you can go and here's where you can get help."

Those are some of the things that I thought of.

Mr. HUGHES. Thank you, Dean.

First, let me thank both of you because it takes a lot of courage to come here and share these insights with us. We are indebted to you for that.

Let me ask you, Paula, how old were you when you first started using drugs?

PAULA. I was 13 years old.

Mr. HUGHES. What was the drug?

PAULA. The first drug I used was alcohol. I tried it, like sips here and there of my brother's beer and then right after that. It wasn't like I'd used alcohol for a little while; it was pot, also, as I experimented with both of them.

Mr. HUGHES. So pot was the second one you experimented with?

PAULA. Yes.

Mr. HUGHES. Any other drugs that you experimented with?

PAULA. Yes. I've done quite a list of them. I've done—do you want me to name them?

Mr. HUGHES. No—well, yes, if you would.

PAULA. OK. I've done pot, alcohol, hash, ups, downs, cocaine, LSD, rush, and PCP.

Mr. HUGHES. Did you smoke when you were in school?

PAULA. Yes.

Mr. HUGHES. OK. Did you smoke at the time that you began tasting beer?

PAULA. No. I smoked a little bit after that. I tried it for a little while and then even when I first started smoking, I didn't inhale or anything like that because it was—I just wanted to do it for acceptance of my friends. After a while, I started to smoke regularly.

Mr. HUGHES. Now, before you started experimenting with drugs, pot and otherwise, had you refused the offer for you to experiment? Did you turn your friends down at first?

PAULA. None of my friends did drugs. I had one friend that did, and I did turn her down quite a few times. Like I said, my brother was into drugs and I saw all the things that he was getting into, trouble with the law, and going to counselors, and I didn't want any part of that. I really looked down on drugs.

I didn't understand them. I didn't know what it was all about. I just kind of went along with my parents and I remember always telling my parents, "No way, there's no way I would ever do that to you all, like my brother did."

But when that one friend, you know, came up to me and kept asking me, I would say no. I looked down on it. After a while, it didn't look as bad as what my brother was doing. I thought, "Well, I can keep it down to a minimum where I wouldn't get as bad off as he was," and so I finally, you know, did it. I tried it a little bit and there wasn't any bad effect. I wasn't getting into trouble with the law. It was fun to me; it was exciting to me.

Mr. HUGHES. Was it curiosity, finally, that got you into drugs or was it some additional peer pressure?

PAULA. A little bit of curiosity, but mostly I wanted the people that were doing it to like me. I really wanted my brother to like me and his friends to like me. Mostly for acceptance of everybody, just to try it. And a little bit of curiosity to see what it was like.

Mr. HUGHES. Did you have any drug education programs in school?

PAULA. The only thing that I can remember as far as that, was a health class that I took. They showed movies; they showed a movie on PCP, and they also had an officer come in with a dummy that smoked a cigarette, and showed us what that did to your lungs.

That was already after I'd gotten into drugs, but other than that, I didn't have any at all.

Mr. HUGHES. I see.

How about you, Dean? I gather you were about 16 when you first began experimenting with drugs?

DEAN. Yes, and I was considered later than most individuals.

Mr. HUGHES. What was your first drug?

DEAN. Alcohol. I experimented with alcohol first.

Mr. HUGHES. You went from alcohol to what?

DEAN. I did pot and I did some of the same drugs that Paula did also.

Mr. HUGHES. Did you smoke cigarettes at the time you went into pot?

DEAN. Later. Later. After I'd been involved with alcohol and pot for around a year, I had started smoking cigarettes.

Mr. HUGHES. Aside from the one program that you had in elementary school, I think you said in fifth grade, on drug abuse, were there any other programs that you received during your formal schooling?

DEAN. There was none. None, to my knowledge, that I can even remember.

Mr. HUGHES. Have you found, since you've become involved in your present activity on the staff, that other youngsters follow your same pattern?

DEAN. Exactly. Definitely. Definitely.

Mr. **Hughes**. You described that families can't identify the problem. Once they finally identify the problem, they don't know how to deal with the problem. Do you find that to be the situation with most of the youngsters you've come in contact with who have had drug problems?

Dean. I think there are several issues in reference to what you're saying. One, parents don't want to look at the problem. They don't want to view the fact that "My son or daughter actually has a problem with drugs," because, of course, then they may tend to look at themselves and feel like, "Well, maybe I'm the cause," and nobody wants to, you know, face that.

Mr. **Hughes**. That they're a failure.

Dean. Right. Exactly. Which would produce guilt or whatever. I think that's one problem, parents don't want to accept the fact that their child is into drugs.

Two, parents who have accepted it and realize that "My son or daughter does have a problem and he's uncontrollable, or she's uncontrollable, and I need some help," don't have the proper outlets or facilities to go to. They don't have the awareness of where to go.

Three, the parents that do go to, say a school counselor or the school dean or the principal, they don't want to hear it and they don't want to look into it. They don't want to accept it.

Those are three problems that I've encountered. There are facilities that do take just the child in by itself, but I think parent support is one of the most important things, because drug use is a family disease; it's not just the individual that has a problem. Sure, they may be using chemicals, but everybody's affected by the user. Just like an adult alcoholic.

Mr. **Hughes**. Thank you.

The gentleman from Michigan.

Mr. **Sawyer**. How old are you now, Dean?

Dean. I'm 19 years old.

Mr. **Sawyer**. Did you finish high school?

Dean. Yes, I've graduated from high school. I'm now in my third semester of college.

Mr. **Sawyer**. Oh, you're going to college in addition to working at the clinic?

Dean. Yes, I am.

Mr. **Sawyer**. Good for you.

Neither of you tried heroin, I assume?

Dean. No.

Paula. No.

Mr. **Sawyer**. And both of you have tried cocaine?

Dean. That's right.

Paula. Yes.

Mr. **Sawyer**. Did you get any kind of an addiction to the cocaine?

Paula. No, I didn't. I tried it, I guess, about seven or eight times and never—not on a regular basis, it was just like every now and then—and I never got a physical addiction at all.

Mr. **Sawyer**. Have you had any recurrent problems from having used LSD?

Paula. No. I used that quite a bit also, and I've never had any flashbacks or anything like that. It's never affected me.

Mr. **Sawyer**. Did you use LSD, too?

Dean. No, I didn't.

Mr. **Sawyer**. How long have both of you been off of drugs?

Paula. I've been off about 2½ years.

Dean. I've been straight for almost 3 years now. I've been straight longer than the amount of time I used drugs.

Mr. **Sawyer**. Are you going to school now, Paula?

Paula. Yes. I just graduated last year and I'll be starting college next week, first year of college.

Mr. **Sawyer**. What do you want to be, Dean?

Dean. Well, right now I'm working toward an associate in administration of justice, which is law enforcement, and human relations, possibly getting involved in the court system, probation officer, which is somewhat ironic to what was discussed earlier about the correlation between people that do drugs and the amount of crime that goes along with it and people that have received treatment and the amount of crime that's with that. It obviously does decrease, definitely.

For instance, for myself, I did do things when I was involved with drugs that violated the law. No. 1, drinking, by itself, was a violation of the law. I was 16, 17 years old. I'm smoking pot. Dealing drugs was involved. A lot of things along those lines. I was breaking the law, and since I've been straight, you know, I've established a totally different viewpoint on the law, and I'm very supportive.

Whereas, opposed to before, I was fearful. Every time I saw a police officer, I was scared because I knew I'd been doing things wrong, where now I don't have to feel that way any longer.

Mr. **Sawyer**. Where'd you get the money to buy these drugs?

Dean. I worked. I had a job and that was part of the thing that I think eluded people. Many people in my past did not know that I used drugs. They didn't know it. They didn't even suspect it because I had a job, for one thing. I made money and supported my habit that way.

Mr. **Sawyer**. How about you, Paula, where'd you get the money?

Paula. I worked for about a year and I supported myself through that. But then I couldn't hold down a job because I doing drugs every single day. I stole from my parents a lot of times. I stole a lot. I remember stealing silverware from my parents and pawning that. getting money that way, stealing money from my brother. Basically any way I could, you know, wherever I could find money, I would steal it from people. That's how I basically got mine.

Mr. **Sawyer**. Dean, what kind of treatment did you receive? What did they do when you went to the clinic, or whatever?

Dean. Well, I was 17 years old when I went to the Straight Program. It was in St. Petersburg, FL; that's where I'm originally from. I now work at a branch program, the Greater Washington Straight Program. That's the program I went into.

When I first went in, I did not think I had a problem for some of the reasons that I listed earlier: I had a job; I made money, but one of the things that——

Mr. **Sawyer**. Why'd you go into the program, then?

Dean. I went in January of 198——

Mr. **Sawyer**. Why? Why?

Dean. Why?

Mr. **Sawyer**. Yes, you said——

Dean. Well, it was not fully my choice. My mother primarily brought me down to the program. She was to the point where she had said I was uncontrollable; I was unmanageable and I was, you know, destroying her life, and that she was going to kick me out of the house the next day.

So she said, "I'd like you to just go down and talk to some people and see if you'd like to consider getting some kind of help, and if you do, I'll be glad to help you out with that. I'll support you."

So, I went down to the program and some people talked to me. A lot of things they said related. A lot of things they said, family problems, problems at school they were having, the feeling or the need to be accepted by their friends, and being weak and falling into acceptance, I could relate to everything they were saying, yet I didn't make the connection with drugs before I came to the program.

I always thought it was just problems I had growing up, when actually those were all just symptoms of my drug use. When they had said, "All those things, Dean, were because they were doing drugs, I was doing drugs," it made me see that I had had more problems than just growing up.

I decided that I did want to give the program a shot, I did want to give it a try. I did, and I'm very thankful that I did.

Mr. **Sawyer**. What kind of treatment did they give you, though? What did they do?

Dean. Well, I was put in a positive peer environment, for one thing. It was a drug-free environment. People were making changes; they were striving toward getting away from drugs, being secure with themselves and their opinions and their feelings to the point where they didn't have to fall into acceptance. They were rebuilding family relationships; people would talk about walking down malls, and holding their mother's hand, and telling their parents they love them, which I hadn't done in a long time.

They were going back to school and getting good grades. That was encouraging to me. It was exciting and I respected people for that. I saw things they were doing—things that I didn't think I could do. That encouraged me because I was in a positive environment.

Mr. **Sawyer**. Was your father living at home?

Dean. No. My parents were divorced at the time, and one common question that was asked of me, what if that had a bearing on my getting involved in drugs, and I said no, definitely not. I was brought up in a very family oriented environment. We had Sunday meals together. My parents never fought in front of me and I think when people direct, you know, the problem at parents, I think it's a copout, and I don't think it's people wanting to take responsibility.

Mr. **Sawyer**. Did your father live at home, Paula?

Paula. Yes, both of my parents.

Mr. **Sawyer**. Did you have somewhat the same kind of treatment that Dean's related?

Paula. Yes, I went into the same program about 4 months after he did and I work on staff now at the same program. When I went in—I mean, I knew I had problems. I knew that I didn't like myself. I didn't like what I was doing. I'd just gotten in trouble with the law right before I went into the program for possession of alcohol.

When I went in—you see, I still didn't associate everything that I was going through with drugs. I didn't know where I was going at first. Then when I went in there, I talked to some people also and I signed myself into the program. I felt relieved, like I wanted some kind of help. I just wanted to get out of the mess I was in. I didn't know how. I didn't know what the program could do, but I kind of felt relieved when I went in. I'm glad I did, too.

Mr. **SAWYER**. Thank you.

I yield back, Mr. Chairman.

Mr. **HUGHES**. The gentleman from New York.

Mr. **SCHUMER**. Thank you, Mr. Chairman. I also want to pay my respect to your courage. Many people who have gone through what you've gone through and some people have rehabilitated themselves, but I think it's very important for you, the rare few, to come forward and let other people know, particularly because there are people who are now in the situation that you were several years ago.

I hope that your being here serves as an example and inspiration to them that they, too, can overcome their problems.

I just have a couple of questions. No. 1, you mentioned many drugs, some of which I wasn't familiar with. What is rush?

PAULA. It's an inhalant. I'm not exactly sure of that, but it's an inhalant that just gives you kind of a real quick high feeling for a few minutes.

Mr. **SCHUMER**. These questions, by the way, are for either Paula or Dean.

From where did you buy your drugs? Were they sold by students in the school or by people outside the school and community?

PAULA. Most of my drugs, I bought in the school from my friends——

Mr. **SCHUMER**. Who are also in the school?

PAULA. Who are also in school. Same grade. My brother, who is older than I was, I bought from his friends. A lot of times, you could just stand outside of a store if you wanted alcohol and ask someone to go in and buy it for you and they would. But mostly it was from my friends at school.

Mr. **SCHUMER**. Dean, the same thing?

DEAN. I purchased drugs from my brother and from friends at school, but I knew I had access wherever I went to get it. Like Paula said, outside a liquor store. I had heard of teachers that used drugs and you know I could have had access to get it that way.

Mr. **SCHUMER**. Teachers would sell drugs to students?

DEAN. Well, this was hearsay. I never myself purchased any from an administrator.

Mr. **SCHUMER**. But do you think the teachers in your school knew that there were drugs being sold and passed around?

DEAN. Definitely.

Mr. **SCHUMER**. And yet they didn't do anything about it?

DEAN. Some would. I think the older teachers—and what I mean by "older" is people—teachers who have been in the school system for 20 years, maybe. There was a lot of teachers at the age from 20 to 30 which were somewhat liberal on the issue.

I'd seen on many occasions discussions that took place in the classroom about drugs and it was like socially accepted. The teachers would laugh or even make comments to kids that they knew were high and not act on it at all.

Mr. **Schumer**. It was said earlier that 1 out of every—I think it was 15—high school seniors smoke marijuana every day. Did anything you hear in the statistical presentation jar your sensibility and not really match what you had experienced?

Paula. Nothing that I can remember. One thing that we had mentioned earlier was the fact that surveys are inaccurate.

Mr. **Schumer**. Right.

Paula. There were two views that I thought of. One was, you know, some people might not lie as much because it is so socially accepted, but then a lot more would lie because there's been so much more crime with it. So many more people getting caught with drugs and a lot more people being scared to get caught. So I think there—the lying part—I thought that was——

Dean. I would have lied. I'll tell you that, I would have lied. OK, if you gave me that questionnaire—I mean, if you gave——

Mr. **Schumer**. Which way would you lie? I could see a reason to lie both ways.

Dean. It would have been that I didn't do drugs; I didn't smoke pot——

Mr. **Schumer**. I see.

Dean. I would have cut down the usage that I did for two reasons: One, to feed my own denial, OK, because if I were to have seen that on paper and all of a sudden the school newspaper came up and said these many people do this and it tells me that they have a problem, well, I would have had to look at myself. Why would I want to do that?

Mr. **Schumer**. Both of you were talking about how you decided to get away from drugs, and most of it seemed to relate to external factors.

What about the physical feelings when you went through it? Were there times where you felt so strung out that you said, "I can't do this anymore"?

Paula. With myself, I was a little bit—I guess I was more, I guess, call it further down than Dean or whatever, because as I got older, I got worse and worse into drugs and I didn't think of responsibility. I just wanted to run away from it.

I failed more and more out of school; I kept quitting jobs and it got worse and worse as I went along.

Mr. **Schumer**. You wanted to get out as it got worse; is that right? You couldn't, but you really had desires——

Paula. Yes, and there were a lot of times when I did use drugs where I got really, you know, like alcohol, I would OD quite a few times and using other drugs where I would just pray that I would come out of the drug, you know, just come out of the physical feeling, but for the most part, the drugs would either make me feel better or just make me feel anything other than, you know, the guilt I was feeling or just the hate that I had for myself.

Mr. **Schumer**. Dean?

Dean. I didn't really have much of a desire to get out because I didn't really think that my problems were all that bad. The problems that I did have, I directed toward other people. I said, "If my mother would change, some things would go better. If the school would not be as strict, then I'd do better." I pointed the finger to everybody else rather than myself.

So I didn't have much of a desire to change and I think this is one of the things. I think the view of people in society, the stereotype of a "druggie" is the long hair, you know, the headband, the concert shirt, the needle and that's not true at all. I had short hair; I dressed fairly nice; I was respectful around teachers and not many people at all suspected that I did do drugs except the immediate family, because they had immediate contact with me.

Mr. SCHUMER. One final question. Do you find that today among your peers drugs are regarded as less of a good thing and more of a bad thing than they once were?

DEAN. I'm not actually back in high school. That was where it actually was, but I think—from what I've been viewing—from what I've been hearing in shopping malls, et cetera, I think people are viewing pot as bad, as not as good for themselves as maybe they would have 2 or 3 years ago because of all the new statistics that have come out. I think that's been helpful. I think that's put a scare into some people.

But I think alcohol is still socially accepted and people don't look at the seriousness of it. When I say, "I've done alcohol," I say I've done the drug "alcohol," not alcohol itself. OK?

Mr. SCHUMER. I think that's very interesting. You talk about alcohol in a very different way than the average American talks about alcohol. You treat it as a drug and something to be feared. That's an interesting observation. The committee ought to take note.

Thank you, Mr. Chairman.

Mr. HUGHES. Thank you.

The gentleman from Florida.

Mr. SHAW. Thank you.

Paula, are you from Florida, also?

PAULA. No, I'm from up here. I went down to Florida into the program.

Mr. SHAW. Oh, you did the St. Petersburg program there?

PAULA. Yes.

Mr. SHAW. How'd you happen to get into that program?

PAULA. My parents attended a neighborhood awareness meeting and they had talked about some convention from Atlanta that maybe some parents would like to attend. My mom went down with a friend and there was a guy there that was from Straight and talked to them and told them all about the program, that it was drug-free, and that it helped, you know, quite a few kids. The word "drug-free" was my mom's—you know, like, yes, that's it, that's got to be it, because all the programs and everything that we'd been to had used drugs to calm kids down.

They called down there and I was put on a waiting list. I don't know what happened; I got in a lot sooner than I thought I would. But my parents drove me down there and they attended an open meeting which gave them a good view of the program.

I went in 2 days later—and they didn't tell me where I was going because I would not have gone in. There was no way that I wanted to change my lifestyle. I didn't think I could, and I really didn't want to. I didn't want to humble myself to my parents and say, "I'm wrong. Look, I've really done bad." I didn't want to tell them all the things I was doing.

So, they didn't tell me where I was going. They said, "You're going to talk to some people about a school," but when I went in there, you know, they told me—they informed me, "Hey, you're here at Straight and it's a drug rehab."

I sat there and I just talked with the people. I was upset, and I was mad because my parents were doing this to me. I just thought it was the worst thing in the world.

But like Dean said, a lot of the things that people were saying I could relate to, and I started feeling more relieved, like, "Hey, maybe I can get out of it." But I still didn't want to look at it as if I had a drug problem. I mean, that just looked so bad in my eyes because in my drug use, I looked at drugs as so good, and I looked at straight people and people that weren't using drugs as that was uncommon and that was really bad.

I really conned myself into believing that drugs were the best thing in the world, and they were my ticket to happiness. If I just kept doing drugs, if I just kept on doing it, somewhere down the line, I would come out on top.

I was 16 when I went into the program and my parents took me down there and I signed myself in. They supported me throughout the whole program.

Mr. SHAW. How long did you stay there?

PAULA. I was in the program for 14 months in all my phases, and then I went on to staff training which, you know, I am on staff now, and it was a group where I was training to be a staff member. Then I went on to staff, so ever since April 13, 1981, I've been involved in the program.

Mr. SHAW. You stayed in the program 14 months? Did you physically stay in St. Petersburg 14 months?

PAULA. Yes.

Mr. SHAW. What problems did you see when you returned back to your own community?

PAULA. Problems with myself or just problems in the community?

Mr. SHAW. Problems with your relationship to your friends.

PAULA. When I came back, most of my friends had already graduated, and I've been back almost a year, and I haven't really had any problems. I've had a few people call me and say, "I'm proud of you," but most of them are scared of me, or just don't want to do anything with me because they know that I'm straight, or whatever.

I really haven't run into any problems.

Mr. SHAW. Were you generally known among your friends for using drugs?

PAULA. Yes, very. I was known among everybody as using drugs and a "freak." You know, with drugs. But I don't know why; I don't know exactly why I haven't had a whole lot of problems with it.

Mr. SHAW. You mentioned that you didn't like yourself when you were using drugs. Did you like yourself before you used drugs?

Paula. Yes. I got really good grades. I was in dancing. I had, you know, I was doing really good in dancing and my parents were really, really proud of me. Yes, I was a very positive person. I really enjoyed it.

Mr. **Shaw.** Now you're 17, going back into your school; did you go back to the same high school?

Paula. When I was down in Florida, I went back as a junior, and I went to a different high school. Then, when I came back up here, I was already graduated through the program. I went back in my senior year and all my friends had graduated, you know, because I had been put back a year because I failed. But I didn't really have any friends that were left in high school.

Mr. **Shaw.** Were you beginning to like yourself at that point?

Paula. Oh, yes. I began to like myself when I first went in the program. On the first phase of the program, I started really liking myself. I started learning that I didn't have to do the things I was doing. I started getting out all the feelings of guilt and disappointment.

Mr. **Shaw.** Did you consider yourself an addict?

Paula. No. No.

Mr. **Shaw.** Do you now consider yourself as a former addict?

Paula. No. I was never——

Mr. **Shaw.** Was it more of an attitude-type of adjustment that you had to get straightened out, rather than a chemical or physical addiction?

Paula. I was chemically dependent on drugs, where I depended on them to feel good or to escape. I was never physically addicted to where I had to have the drugs, but I was chemically and emotionally, like in my head, I wanted the drugs; they made me feel good, so therefore I used them to escape everything else that I was going through, skipping school, fighting with my parents, things like that. But I was never physically addicted to any drugs.

Mr. **Shaw.** How did your parents first find out that you were involved, and how long were you involved, with drugs before they did find out?

Paula. I would say it was about 8 or 9 months before they found out. It was pretty quick, because my brother had gotten into drugs and they were aware of all the symptoms that led up to it, so they caught on to me pretty quick. My dad had found drugs in my purse and they confronted me with them. I said, "Well, they aren't mine," and they didn't believe me. There are times I came home late, you know, with alcohol on my breath and I said, you know, "Oh, I just had one drink." I was lying to them all the time.

Mr. **Shaw.** Do you use alcohol at all now?

Paula. No, I don't use any drugs at all.

Mr. **Shaw.** Is it your intention never to use alcohol?

Paula. Yes. I won't ever touch any alcohol or any drugs or anything, ever again.

Mr. **Shaw.** Dean, do you feel the same way about alcohol?

Dean. Definitely. Like I said earlier, alcohol is a drug, in my opinion. When I've made that decision that I felt bad and I knew that drugs—meaning alcohol or whatever else—would make me feel better, and I actually carried out that act, then I think that was the time when I became chemically dependent, and I think that's the time when anybody crosses that line is when they know that, "Hey, this will make me feel better, and I feel bad now, so I'm going to go to that to feel better."

I think that's when that line's crossed and I think—I know, in fact—that I crossed that line. So I can't go back.

Mr. **Shaw**. Did you feel that you were addicted to alcohol or any of the chemicals?

Dean. Yes. I think people say "addict." You know, when I talked earlier to somebody, they said, you know, I've heard several people say I'm a "junkie," or I'm this or that. I don't view myself as that. I view myself as being chemically dependent. I know that I was habituated to drugs to the point where I knew when I felt bad, I could use them to feel better, rather than go to the proper channels, which I think any young adult should go to, which is to talk about my feelings, go to my family, express, "Hey, I'm feeling pressure from school to be accepted, to do this and that." I mean, that's normal mechanisms that I should have been using growing up, but I didn't.

In turn, I used drugs. And that screwed up my whole system, you know. I didn't have the mechanisms to deal with everyday problems inside of me. My mechanism was drugs. In turn, I had to reestablish all of that when I went to the program and I had to learn how to deal with my feelings, learn how to deal with being accepted and all that within myself.

Mr. **Shaw**. Had you gotten to the point where you didn't like yourself much?

Dean. Yes. I was to that point, because I thought that I had problems that other people didn't have. Of course, some of my family problems—one of the main things with me was I felt so weak over wanting to be accepted by other people. I think that's one of the prime problems, that peer acceptance—I mean, that's what primarily got me into drugs. I just felt so weak that I couldn't even stand up for myself. I knew I was that way when I was younger and——

Mr. **Shaw**. Why was that? Was that because of your attitude or the fact that you may have been a little more extraverted when you were under the influence of the drugs, or was it just because you wanted to be seen with a marijuana cigarette in your hand or a cocaine spoon or something of that nature?

Dean. I think I primarily just wanted to be known as somebody that was popular. I knew that drugs were a popular thing. Going out and getting drunk on the weekends was a popular thing to do.

Mr. **Shaw**. Thank you. Thank you, both, for coming to visit with us.

Mr. **Hughes**. I just have a couple of very brief questions.

When you purchased the drugs at school, were they in most instances purchases from your friends?

Dean. Yes.

Mr. **Hughes**. Were they selling drugs to make money or were they selling drugs just to get them over to their other friends?

Dean. I think a mixture of both. I think, for one thing, at least for myself, when I first tried to get other people into drugs, I didn't make them pay at first because I wanted to bring them down; I wanted to get them into the scene, make them feel like I was doing something good for them, you know.

But later, when the person actually came to the point where they wanted the drugs, then they started paying. I think some was to make money, but most of my friends I knew that sold drugs, it never worked out that way. They did half the drugs that they were supposed to be selling, so it came to the point where they were just making enough money to purchase.

Mr. HUGHES. OK, just one additional question. Looking back now to your days in high school in particular, knowing what you know now, what do you think would be the single most important thing we could do to try to reach that individual who's trying to make a decision whether or not they should experiment with drugs?

PAULA. I guess the thing that I can think of is having speakers like Dean and myself go to schools and maybe hold classes, like in health classes, such as I had, to give them more knowledge on the drug use, what it does to you physically and mentally. Have people that have experience with drugs and have them go talk to them, because it got my attention more when people my own age were saying, "Hey, I've been there and this is what I've done and this is what it's done to me." It made me want to believe it a lot more than just a parent lecturing or a movie that——

Mr. HUGHES. Are you doing that now? Are you going into a school, for instance, and telling your story?

PAULA. I've done a few speaking engagements, but none in a school. I attended a school and I would talk to parents—I mean, teachers and counselors, about myself.

Mr. HUGHES. How about you, Dean?

DEAN. I personally haven't been to a school, but I think an opinion on what you're saying, I think it would need to go way back to elementary school and start early because—the things that I did people would talk about, like when TV programs would come on and talk about the effects of pot or the effects of cocaine or alcohol or that have former users on TV. I would look at them and I'd think, "Wow, they actually changed."

It would be a little bit exciting to me. I'd think, "Wow, they can actually change," and I saw what they were saying and it would scare me some, but I was already to the point where I needed some kind of treatment to stop. I couldn't just do it by myself.

I think having people like myself or Paula going to—of course, with the counsel or whatever, some type of presentation or awareness meeting of some sort back in the schools would help people like myself because I know I could go and say, "Hey, look, I did drugs; I wanted to be accepted; I wanted the acceptance of friends; I thought I'd be cool; I thought I'd have a bunch of people that I could trust; I thought I'd be happy; and I didn't get that at all."

Now, since being straight, I can be strong with my opinion and I can feel good. I can do good in school and I don't have to worry about what other people think about me, et cetera.

Mr. HUGHES. Well, thank you very much. You really have, first of all, contributed immeasurably to the hearing and we are indebted to you for coming.

As I indicated, you're courageous; your candor is refreshing; and we certainly appreciate your insights. We wish you continued good health and success in everything you do.

Paula. Thank you.

Dean. Thank you very much.

Our next panel this morning consists of three of the most prominent figures in the country who administer at the State level programs that support drug abuse prevention and research. First, Thomas Kirkpatrick, Jr., is the executive director of the Illinois Dangerous Drugs Commission, a position he's held since 1975. Mr. Kirkpatrick is also the president of the National Association of State Alcohol and Drug Abuse Directors. He is a member of the National Advisory Council on Drug Abuse and has been appointed secretary and presiding officer of the Council by NIDA Director, Dr. Pollin.

In 1980, he was appointed by President Carter as a member of the National Strategy Council on Drug Abuse. Mr. Kirkpatrick is a lawyer by profession and has had an extensive career in law enforcement, with the Law Enforcement Assistant Administration, and with the Drug Abuse Council before he took his current position.

Our second witness is John Gustafson, the deputy director of the Division of Substance Abuse Services for the State of New York. Mr. Gustafson testified before the subcommittee a number of years ago on the relationship of drugs and crime. For the past 13 years, Mr. Gustafson has worked in almost every capacity in the management and planning of drug abuse services for the State which probably has the greatest drug abuse problem in the Nation.

Most recently, he has been working with numerous communities throughout New York to generate locally based drug abuse prevention initiatives.

The third member of the panel is Richard Russo, the assistant commissioner of Health for the State of New Jersey, who is also the director of the Division of Narcotics and Drug Abuse Control. Mr. Russo's very distinguished career in the New Jersey Department of Health goes back to the beginning of the 1960's. Mr. Russo has degrees in pharmacy and in public health, and is the author of numerous articles on these subjects and is a member of many professional societies and organizations.

Mr. Russo manages over 570 employees and has a budget of some $6.3 million for alcohol programs and a $17.8 million for drug abuse.

Gentlemen, we have your statements which, without objection, will be made a part of the record and you may proceed as you see fit. Welcome. Let's begin first with you, Mr. Kirkpatrick.

TESTIMONY OF THOMAS KIRKPATRICK, JR., EXECUTIVE DIRECTOR, ILLINOIS DANGEROUS DRUGS COMMISSION, AND PRESIDENT, NATIONAL ASSOCIATION OF STATE ALCOHOL AND DRUG ABUSE DIRECTORS; RICHARD RUSSO, ASSISTANT COMMISSIONER, NEW JERSEY DEPARTMENT OF HEALTH; AND JOHN GUSTAFSON, DEPUTY DIRECTOR, DIVISION OF SUBSTANCE ABUSE SERVICES, STATE OF NEW YORK

Mr. KIRKPATRICK. I thank you, Mr. Chairman. With your permission, since you do have the written statement for the record, I'd just like to make a few brief points——

Mr. HUGHES. We'd appreciate that.

Mr. KIRKPATRICK [continuing]. And make ourselves and myself available for your questions on issues that have been raised so far.

I think the one issue that has been identified early on in these hearings, and one of great concern to us, is the shift in responsibility as it was described to the States for the administration of all of the Federal money for drug abuse treatment and prevention. We have calculated that this will cause a 42-percent reduction in the available funds from 1980 to 1983.

That is the actual dollar reduction and figure again the 2 years of inflation at a 10-percent rate for the first year and a 6.3-percent rate for this third year. Unfortunately, a lot of people judge the impact of increased cost as being a soft figure and not a hard one in terms of what's available. However, I can tell you that in years where inflation runs high, we've had to reduce our programs and services by as much as 10 percent, even though the dollar amounts stay the same that are available in a particular area. So it's a very real cost factor.

Costs have been increasing and the available dollars through the ADM block grant have been decreasing, and yet there is an unparalleled increase in demand for services. In a recent survey of our States, 94 percent reported that they are unable to meet the demand for drug abuse treatment and prevention services.

The increased concern in many large States is with the criminal justice system and its problems, its prison overcrowding, the need to find alternatives to traditional prosecution, and incarceration for persons whose real problem is drug and alcohol abuse. There is an increased demand in those large States by the judiciary and by the prison system for more treatment services to deal with those people for which no services presently exist.

There was a mention earlier in these hearings of the relationship between the eradication programs and the border interdiction programs and the treatment and prevention programs and I think almost everyone who has testified has stated that both are necessary and it's absolutely true that law enforcement, of which I've had a personal background in border interdiction and crop eradication, is a short-term suppression program. The true answer—and it's unfortunately a long-term one—to doing anything about the problem that faces us with regard to drugs, is to change the attitudes, to change the demand for drugs, and to increase the knowledge and awareness of what drugs are all about and why people find themselves involved in it.

Unfortunately, that takes a long time to make those kinds of changes, so in the meantime, we have to have the law enforcement interdiction programs as much as we need the treatment and prevention programs.

We have a couple of quick points to make and they are that as an association, there are several matters before Congress that we're concerned about, in addition to the appropriation level, and they include the possibility of funding for activities that would be permitted under the Justice Assistance Act to continue to fund programs such as the Treatment Alternative to Street Crime Project, the so-called TASC programs which in many States, including my own, provide probably the only contact between the overburdened court system and the available treatment resources.

Another issue identified by an earlier witness in response to a question by a member of the committee, is prescription drug abuse and licit drugs diverted to the illicit market. We would like to see and would support the Drug Enforcement Administration being able to provide financial and technical assistance to the States, who have the primary responsibility for controlling prescription drug abuse as we do.

The third concern is the imminent danger that as an association, we believe that as public resources for publicly funded drug abuse treatment and prevention programs decline, the quality must therefore also decline. The available services will deteriorate and what we will have is a two-tiered structure of services, as has happened in some other areas—an underfunded and underqualified one for publicly funded services and a very expensive one available only to those persons who have private resources available to pay for their service.

We would also like to point out that we do appreciate very greatly the research that has been conducted by the National Institute under Dr. Pollin's direction and continues, because we believe there are answers to be found to many of these problems in research. However, we are not in the position of being able to put signs in our programs saying, "Closed until research finds the answer." Most of the significant research efforts are 5-, 10-, and 15-year projects. We support it; we appreciate it, but we're faced with having to do something about the problem now.

Thank you.

[The statement of Mr. Kirkpatrick follows:]

TESTIMONY OF THOMAS B. KIRKPATRICK, JR., PRESIDENT, NATIONAL ASSOCIATION OF STATE ALCOHOL AND DRUG ABUSE DIRECTORS, AND DIRECTOR, ILLINOIS DANGEROUS DRUGS COMMISSION

Dear Chairman and Members of the Subcommittee: The National Association of State Alcohol and Drug Abuse Directors (NASADAD) is pleased to have this opportunity to present a statement for the Subcommittee hearing record on the status of the publicly funded alcohol and drug abuse treatment and prevention services in the 50 States and U.S. Territories.

The State Alcoholism Agencies and the Single State Agencies for Drug Abuse Prevention were created by the States in response to Congressional action in the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 and the Drug Abuse Office and Treatment Act of 1972, respectively, to have sole responsibility in the States to plan and administer a Statewide alcoholism and/or drug abuse prevention and treatment network.

Under the Omnibus Reconciliation Act of 1981, which created the Alcohol, Drug Abuse and Mental Health Services (ADMS) Block Grant, Federal mandate for Single State Agencies was repealed. However, I am pleased to inform you that each State and U.S. Territory has chosen to retain this governmental structure in order to assure effective coordination of alcohol and drug treatment and prevention services at the State and local level and efficient administration of the relevant portion of the Federal ADMS Block Grant.

The Chairman and members of the Subcommittee are already familiar with the range and complexity of problems which result from alcohol abuse and alcoholism, licit and illicit drug abuse addiction; these are problems which impact on every sector of our society, whether it be lost productivity at the workplace, accidents on our highways, or disruption of the family unit. Our children are not immune from the problem nor are the elderly. A 1982 study sponsored by the Alcohol, Drug Abuse and Mental Health Administration estimated the economic cost of alcohol and drug abuse to have been $65.8 billion in 1977. Also, a recent study by the Congressional Office of Technology Assessment (OTA) projects that the costs for alcohol abuse alone will have approached $120 billion for 1982.

The project economic losses due to alcohol and drug abuse do not seem excessive when you consider the following:

An estimated 10 million American adults are problem drinkers or alcoholics—more than $3 million American teenagers abuse alcohol;

10,000 young people are killed every year in highway accidents involving alcohol;

American youth still have the highest level of drug abuse in any industrialized nation;

33% of all Americans over 12 have used an illicit substance or a prescription drug for non-medical purposes;

Heroin addiction remains a serious problem in our large, urban areas; and

Almost one third of all State prisoners in 1979 were under the influence of an illicit drug when they committed the crimes for which they were incarcerated.

In light of this evidence it makes sense in both fiscal and human terms, for both Federal and State governments to invest in an appropriate level of funding for the prevention and treatment of alcohol and drug abuse.

Historically, the Federal-State partnership has been a strong, mutually supportive one. However, over the past three years Federal support for alcohol and drug abuse treatment and prevention has been reduced by 42 percent. This reduction has placed an unfair burden on State governments and one which many State governments have been unable to assume. As a result, the ability of publicly-funded alcohol and drug abuse programs to meet the increasing demand for services has been severely hampered.

ALCOHOL, DRUG ABUSE AND MENTAL HEALTH BLOCK GRANT

Overall, the State alcohol and drug abuse agencies have made a smooth transition from the previous Federal categorical alcohol and drug project and formula grant programs to the Alcohol, Drug Abuse and Mental Health block grant program. The smooth transition is in part due to the fact that the State drug agencies had been receiving their project grant dollars through a mechanism similar to the block grant for several years—the Statewide services grant—and were already responsible for allocating and monitoring the Federal drug abuse project grants. Also, at the tme of the ADM block grant authorization, Federal officials were considering switching to a Statewide services funding mechanism for the Federal alcoholism project grants, which at that time were being administered by NIAAA. In fact, five States were participating in a demonstration project testing the feasibility of the Statewide services grant mechanism for the alcoholism project grants. Both the alcohol and drug abuse formula grants were awarded directly to the State alcohol and drug agency, which in turn allocated the dollars where they were needed most.

Since the State alcoholism and drug abuse agencies were already administrating three-fourths of the programs eventually folded into the alcohol and drug portion of the ADM block grant program, the basis for the supposed administrative cost savings associated with the ADM block grant—streamlined and efficient management—was not applicable. The funding reductions accompanying the block grant were supposed to be balanced by the increased costs savings realized from the new funding and administrative mechanisms. Unfortunately, for the alcohol and drug services programs the supposition was not relevant. Rather they were penalized for having been one step ahead.

In FY 1980 (the year for the alcohol and drug portion of the ADM block grant), Federal appropriations for the alcohol and drug abuse project and formula grant programs totalled $322 million. In FY 1983 the alcohol and drug protion of the block grant equalled only $222.8 million—a 33 percent reduction from FY 1980 levels without adjusting for inflation. If the inflation rate of 10.4 percent in 1981 and 6.1 percent in 1982 is taken into account, current Federal funding levels for alcohol and drug treatment and prevention services represent a 42% reduction in real dollars.

Recognizing the increased demand for alcohol and drug treatment services by the unemployed, Members of Congress added $30 million to the ADM block grant FY 1983 appropriation in the recently enacted-package of jobs and humanitarian aid for the unemployed. Even with this increase of $15.2 million (the alcohol and drug portion of the ADM block grant equals 50.76% of the total), Federal funding for alcohol and drug services, when adjusted for inflation, has decreased 33% from the FY 1980 level.

In the Chairman's home State of New Jersey, treatment and prevention funding for drug abuse has been reduced over the past several years by $5,000,000. Approximately $3,000,000 of the reduction is the result of the switch from Federal categorical monies to the ADMS Block Grant program. The State budget was also decreased by $800,000. Because of the funding reduction, the number of treatment agencies has dropped from 97 to 80, the annual number of clients receiving substance abuse treatment services from 21,000 to 15,000; and New Jersey's daily treatment capacity has been reduced from approximately 7,500 to 6,690 as of January, 1983. Unfortunately, the demand for treatment services has continued to exceed the State of New Jersey's capacity to respond.

Many States, with careful budget planning combined with a temporary overlap of Federal funding have been able to maintain a minimum level of services even with the significant reduction in Federal support. In FY 1982, many States received their FY 1982 block grant award prior to the expiration of their previous fiscal year's project and formula grants. This phenomenon was due to the unforeseen delay of previous Federal grant awards in many States where the fiscal year award was not made until six months after the beginning of the fiscal year. For example, State X applied for and received its FY 1982 block grant quarterly allocation on October 1, 1982. However, State X's FY 1981 Statewide services annual grant award had not been awarded until March 1982 (six months after the beginning of FY 1981). As a result, there existed on overlap of Federal Funds and the State was able to postpone the negative impact of the decrease in Federal funding for alcoholism and drug abuse services which accompanied the ADMS block grant. With creative planning, many States have been able to stretch this cushion into the 1983 Fiscal Year, but it will go no farther. Beginning in FY 1984, many programs in the 50 States and U.S. Territories will close their doors, in a time when these programs are needed the most—during and immediately following a period of high unemployment. State revenues are not available to bridge this funding gap since State coffers are being drained by the provision of minimal welfare and social services benefits to the unemployed and their families.

In the State of Michigan, the largest increase in client admissions has come from the category of those "unemployed and in the work force" meaning those recently laid off and looking for work. Overall, 63 percent of the 75,600 clients admitted to publicly funded substance abuse programs in Fiscal Year 1982 were unemployed—an increase of more than 10,000 from FY 1978-79. As in New Jersey, however, there are no additional resources available to support the increased demand for services. Hundreds of clients are being forced to wait for services.

SURVEY OF STATES

If I may, I would like to provide you with the results of a survey conducted by NASADAD last March on the status of State alcohol and drug abuse services systems. In the survey of the NASADAD membership, each State agency director was asked to provide a narrative description of any significant changes in the delivery of prevention and/or treatment services over the past year. State Directors were then asked to offer projections on future State (not Federal) resources. A brief State-by-State summary of the comments made in response to both of these questions is attached for your information.

In general, the comments made by the State agency directors reflect the uniqueness of the States and their service needs. Many of the States have increased their expenditures for prevention programs, a change which appears to be related to the ADM block grant requirement that 20 percent of the ADM block grant dollars be allocated for prevention, while in other States the directors have independently decided to increase prevention services using State monies. In many States (eleven) the capacity to support treatment services declined in FY 1983; even though the perceived need in those States had increased due to economic conditions. In several States, there has been a change in the type of treatment services provided, with less chronic and/or institutional care and more early intervention type care.

Regarding FY 1984 State monies for alcohol and drug abuse services, the majority of States expressed hope that they would be able to maintain their current level of services for at least part of the fiscal year, only seven States indicated that they expected to receive funding increases in FY 1984. In these instances, the program increases seem to be related to projected alcohol tax increases, to commitments related to drunk driving programming and/or to the expansion of prevention programs. Ten States indicated that they expect to suffer significant reductions in funding in FY 1984.

Of greater importance is the fact that over 94 percent of the States responding to the NASADAD survey reported that an unmet need for treatment and prevention services exists within their State. Thus, even though the State may be able to maintain current services levels, it is not enough—there are still thousands of individuals who need and could benefit from some type of prevention or treatment services.

RECOMMENDATIONS

I would like to applaud the members of the Subcommittee on Crime for its assertive approach to identifying ways for the Federal Government to assist in reducing the problems of alcohol and drug abuse in our society. Your sponsorship of legislation designed to assist in not only reducing the availability of licit and illicit drugs, but also your concerns for helping the victims of alcohol and drug abuse is welcomed by the national, State and local constituency groups, and everyone who has ever encountered these problems.

If I may, I would like to briefly comment on three pieces of legislation which fall within your Subcommittee's jurisdiction—the Justice Assistance Act which has passed the House of Representatives, prescription drug abuse diversion amendments proposed by the Administration, and the Comprehensive Drug Penalty Act of 1983.

Justice Assistance Act

NASADAD strongly supports the concepts of a block grant program to States for the purpose of carrying out programs of proven effectiveness or which offer a high probability of improving the functions of the criminal justice system as proposed by the Justice Assistance Act. Many States have been intimately involved with the highly successful Treatment Alternatives to Street Crime (TASC) program which is one of the specified categories of criminal justice programs which can be funded under this block grant program. The TASC program seeks to develop linkages between the criminal justice and alcohol and drug treatment systems as well as reduce recidivism among drug or alcohol abusing offenders. Federal support for programs such as TASC must continue if we are to continue to adequately address the needs of this population which is responsible for a significant portion of property crime in our cities.

NASADAD encourages the Subcommittee on Crime to recognize that the responsibility for implementing and operating programs such as TASC must be assumed by both the Federal and State governments. It is no longer appropriate for the Federal government to simply provide "seed money" to the States, nor is it appropriate for the Federal government to restrict the duration of joint Federal-State support to a particular time frame.

As I am sure you are aware, the FY 1984 appropriations measure for the Department of Justice as reported by the Appropriations Committee does not include funding for the Justice Assistance Act's block grant program. NASADAD, through its Legislative Committee, has been seeking support for inclusion of an appropriation for this important program and we encourage you to continue to place a high priority on obtaining funds for the block grant program.

Prescription drug diversion

The Subcommittee is to be congratulated for its attention to the very serious problem of diversion and abuse of prescription drugs. Under consideration for some time has been a grant-in-aid program in DEA to assist States to develop integrated and effective diversion control programs. NASADAD strongly encourages the Subcommittee to authorize such a program which would provide incentives to States to evaluate their diversion problems and develop strategies for improving their response. The Drug Enforcement Administration should also be encouraged to develop a program of technical assistance to States, including assignment of new field office personnel to serve as a proactive liaison to State licensing, regulatory and enforcement agencies.

Civil forfeiture provisions

I would also ask the Subcommittee to consider including language in the civil forfeiture provision of the Comprehensive Drug Penalty Act of 1983 which would permit a portion of funds collected by authority under this provision to be allocated for drug abuse treatment services. NASADAD endorses the concept that assets and profits derived from illegal drug trafficking should be utilized, in part to support activities in the area of drug enforcement. However, it is just as appropriate for a portion of the seized assets to provide additional treatment capacity for drug addicts and abusers.

Treatment programs for alcohol and drug abusers lacking private or third party coverage rely heavily on Federal and State government resources. With the current reduced level of Federal support, quite often it is the alcoholic or drug addicted criminal offender who does not receive the appropriate treatment. I believe your Subcommittee's authorization of the criminal justice block grant can play an important role in improving services for this population, as could legislation permitting a portion of funds and assets seized through civil forfeiture legislation to be dedicated to treatment of drug abuse problems, easing some of the demands placed on our services systems.

NASADAD also encourages the Subcommittee on Crime to recognize the important contributions of the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA). The Institutes' research programs have helped us to better understand alcoholism and drug addiction and also play an important function by monitoring national and regional drug abuse trends.

In closing, I encourage the Subcommittee to recognize that the publicly-funded alcohol and drug abuse services programs which rely on Federal and State funds remain effective providers of low cost, quality services. However, without an increase in Federal support, at least to its previous level, I expect to see a gradual deterioration of the alcohol and drug abuse services systems in some parts of the country within the coming year. I would like to once again express my appreciation and the appreciation of my fellow State alcohol and drug abuse directors for your active interest in seeking ways to build upon the Federal-State partnership in the alcohol and drug abuse fields.

Thank you.

Attachment 1.—Changes in Status of Services Systems in Fiscal Year 1983 [1]

ALABAMA

Treatment: reduced dollars for inpatient & outpatient services. Prevention: doubled dollars and services.

ALASKA

No major changes—under Block Grant continued programs funded by Feds.

ARIZONA

Alcohol: more early intervention & less chronic care. Drug: expanding methadone maintenance & registering prevention service clients.

ARKANSAS

Need to expand outpatient & residential alcohol treatment by 80%. Need education on cocaine. Need more attention to DWI & other alcohol related arrests; need more residential drug treatment for youth.

CALIFORNIA

Are cutting State Operations Staff by 50% (200 to 100 persons), but treatment and prevention are OK.

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[1] From NASADAD survey of membership conducted March 1983. Please note this is a brief Summary of a much more extensive narrative provided by the States.

COLORADO

DWI evaluation/referral & treatment was transferred from highway office to SAA.

CONNECTICUT

Active movement to more social setting detoxification; also active in areas of Parent Youth Professional Conferences, DWI Task Force, & shelter/alcohol services for homeless.

DELAWARE

No major changes due to overlapping and carry over dollars.

FLORIDA

More group counseling (& less individual counseling); some cuts in client services.

HAWAII

Treatment programs are struggling to stay open.

ILLINOIS

Alcohol: focus is on services in community settings rather than in State facilities: Drug: treatment capacity has been reduced due to funding cuts and a decision to increase the slot reimbursement rate to bring it closer to actual costs; have increased support for prevention programs.

INDIANA

FY 83 dollars up 20 percent over FY 82 due to use of overlapping funding dollars and State dedicated tax dollars (passed in 1981); expanded all services.

IOWA

Not much change, although some increase in prevention services.

KENTUCKY

Replaced grant mechanism with a fee for service system. Increased emphasis on primary prevention.

LOUISIANA

New DWT legislation effective 1/1/83, but do not yet know its impact on service demand.

MAINE

New premium law on alcoholic beverages resulted in increased dedicated revenues for alcohol services and mandated interdepartmental cooperation. Have increased levels of both treatment and prevention including both services to institutionalized substance abusers and prevention directed to younger earlier stage drinkers.

MARYLAND

Block Grant led to increased dollars for prevention. Also have implemented Statewide EAP.

MASSACHUSETTS

Use Block Grant process to cut poor performing programs and fund improved programs more responsive to needs, e.g., for minorities & Hispanics. Used overlap dollars to extend services over time; Block Grant is a grand idea and preferable to direct Federal funding of local programs.

MICHIGAN

Substance abuse programs & staff have been cut. Client waiting lists are up; more clients are unemployed.

MINNESOTA

Have experienced funding cutbacks, especially for public clients (e.g., in medical assistance); now send clients to State hospitals.

MISSISSIPPI

Some cuts in funding.

MISSOURI

Adopted comprehensive services model & service area planning/resource allocation concept; transition from State hospitals to community based programs and services.

MONTANA

Have maintained services at level prior to Block Grant funding.

NEVADA

Using newly available alcohol excise tax monies earmarked for substance abuse services. Civil Protective Custody and Detoxification Services have been expended in some parts of the State. Due to the Block Grant requirement some programs have refocused their activities from treatment to prevention, resulting in a decrease in the number of treatment slots available. Due to the economic recession, Federal funding cutbacks and shrinking alternative funding sources, many alcohol and drugs treatment and prevention programs are operating at extremely critical financial levels.

NEW JERSEY

Due to funding cutbacks some programs have been reduced in size or closed. However, two small new programs have been opened to serve financially and medically indigent women.

NEW MEXICO

Over past year treatment service needs increased 35% and prevention service needs increased 50%.

NEW YORK

Drug: Lost 32% Federal dollars in transition to Block Grant therefore have fewer dollars at a time of increasing need; looking to alternative financing through private health insurance, EAPs, etc. Alcohol: The past year has been a significant one for alcoholism services. New legislation related to drunk driving has resulted in the availability of fine money as a match for State administered funds on a 50/50 basis. The new Governor, Mario M. Cuomo, in his State of the State Message announced his intent to introduce and strongly support legislation mandating insurance coverage for alcoholism services. Governor Cuomo also highlighted employee assistance programs and prevention services as priorities for his administration.

NORTH CAROLINA

Funding has remained relatively stable although it has not kept pace with inflation.

NORTH DAKOTA

Became more active in prevention programming & hired a State Prevention Coordinator.

OHIO

Drug: Lost Federal dollars in Block Grant, Title XIX & XX reductions & also State unemployment & deficits leading to State deficits leading to State dollar reductions; therefore have consolidated & merged programs, combined alcohol & drug programs; developed more EAPs, decreased services provided, length of treatment & number of clients served; have wider range of prevention services. Alcohol: increases in private hospital based programs & youth prevention programs.

OKLAHOMA

More concentration on treatment services for youth & adolescents & on prevention services.

OREGON

Major change has been to support services on a slot funding basis. Also closed the alcohol & drug ward at Oregon State Hospital & moved intensive services to a non-hospital setting.

PENNSYLVANIA

Used forward funding of grantees to ease 25% Federal funding cut; made 15% cut in period ending 6/83; stable 7/83 to 6/84, & project 10% additional cut in 7/84 to 6/85.

RHODE ISLAND

Need has increased due to unemployment & DWI referrals; waiting lists are longer, but have fewer dollars available to meet the needs.

SOUTH CAROLINA

Due to revenue shortfalls State FY 83 monies were reduced by 9%, but programs were not reduced; used Block Grant monies to expand prevention services and programs.

TENNESSEE

Two significant changes: (1) notable increase in prevention funding plus targetting to areas of Fetal Alcohol Syndrome early intervention with high risk youth, & teacher training; (2) shift of detoxification & intensive residential services from institutional to community based programs.

TEXAS

Drug: Major expansion of prevention services especially for at risk youth; also decrease in treatment services (6% since FY 82 & 11% since FY 81).

UTAH

Significant increase in funding for prevention programs; also implemented a Public Inebriate Program including $1.5 million in earmarked monies from alcohol tax increases.

VERMONT

Doubled State support for prevention activities. Reduced support for some treatment programs due to Block Grant cut.

VIRGINIA

Support community based programs, citizen involvement, & interface between treatment & criminal justice systems.

WASHINGTON

Experience major cuts in FY 83 (e.g., 37% in drug outpatient services. Also major cuts in education, prevention, training & project grants). Block grant mehcanism did not have a major impact although did expend some dollars differently.

WEST VIRGINIA

State Supreme Court ruled that incarcertation of chronic alcoholic for public intoxication is illegal and State must provide appropriate care. State and community behavioral health centers reallocated dollars to provide 24 hour screening, medical referral and shelter care.

WISCONSIN

A major reorganization has taken place within the State agency, resulting in a significant reduction in staff.

WYOMING

With State dollars increase of about 25 percent, residential treatment services were increased.

ATTACHMENT 2.—PROJECTIONS FOR STATE MONEYS IN FISCAL YEAR 1984

ALABAMA

Hope for stable funding in FY 1984; do not expect to obtain requested increase.

ALASKA

In FY 1984 expect 2⅓ million cut in State monies (16%) and will have to eliminate programs.

ARIZONA

Expect significant reductions in FY 1984 State dollars (7 to 17%).

ARKANSAS

Expect 7% increase for treatment to cover inflation costs. Are no general revenue State dollars for prevention services.

CALIFORNIA

Expect stable Federal and State dollars for local programs, but don't know of county dollar level.

COLORADO

In FY 1984, expect a maintenance level budget.

CONNECTICUT

Expect at least stable funding plus 5.8% increase for community grants, and if tax bill passes, could receive $1.5 million.

DELAWARE

In FY 1984 will reduce number of programs (but costs not due to dollars); expect major dollar problems in FY 1985.

DISTRICT OF COLUMBIA

Have requested a major funding increase, but don't know whether it will be granted.

FLORIDA

Some overall cuts in alcohol services, although more dollars for DWI & residential youth alcohol treatment; expect some increases in drug abuse services.

HAWAII

Expect a slight decrease in State monies in FY 1984.

IDAHO

Expect a decrease in State monies in FY 1984 of $300,000, but will try to reduce the impact of this cut in services through faster utilization Block Grant monies; crunch will come in late 1984 or 1985.

ILLINOIS

Alcohol: expect some funding cuts in FY 1984. Drug: in FY 1984 the budget will probably remain at about the current reduced level.

INDIANA

Expect FY 1984 budget increase of 13%; will expand court alcohol and drug services programs by 50% in 2 years; priorities are youths residential treatment and youth prevention and early intervention.

IOWA

Future is difficult to project; probably will be stable although could be some reductions, or if dedicated tax is passed, some increases.

KENTUCKY

Expect status quo for FY 1984 State service funding.

LOUISIANA

Expect budget cut of approximately 15% & further reorganization & consolidation of clinical facilities to cut costs.

MAINE

Some new monies may be authorized, but they may be offset by declining alcohol sales and premium revenues.

MARYLAND

Expect stable funding with exception of increase in outpatient services related to comprehensive DWI program.

MASSACHUSETTS

Expect at least stable funding & possibly some increases. (Alcohol agency); hoping for stable funding (Drug agency).

MICHIGAN

Hope for stable funding levels, with increased State taxes, insurance dollars, DWI fees, etc.

MINNESOTA

Hope for stable funding.

MISSOURI

Hope to work with General Assembly to generate resources required to meet needs.

MONTANA

Expect funding to remain stable (have earmarked alcohol tax dollars going to counties).

NEBRASKA

Expect no increase in State dollars; problems will occur in FYs 85 & 86 once carryover funds are depleted (programs may have to be cut 20 to 30%).

NEVADA

State General Fund appropriations over the period FY 1983—FY 1985 have been cut substantially.

NEW HAMPSHIRE

If the initial budget is adopted services will be cut, but if alternative funding measures pass then services could be increased.

NEW JERSEY

Hope to maintain current funding level and support existing programs.

NEW YORK

Alcohol: Expect continuation of current level of State support. Drug: Proposed State budget projects stable State funding but cannot make up Federal funding cuts concurrent with Block Grant implementation therefore are experiencing cuts at a time of expanding needs.

NORTH CAROLINA

In FY 83-84 expect stable funding but will transfer dollars from institutions to communities for alcohol services.

NORTH DAKOTA

Don't know, but hope for stable funding in FY 1984.

OHIO

Drug: Hope to obtain maintenance level of funding, including more State dollars to make up for loss of Federal dollars.

OKLAHOMA

Due to declining tax revenues (oil glut) expect cuts of about 6% in State support.

OREGON

Expect to maintain current level of services & funding in FY 1984.

PENNSYLVANIA

Hope for stable funding in FY 84.

RHODE ISLAND

Expect some cuts in State dollars that will lead to service cuts at a time when needs are increasing.

SOUTH CAROLINA

Future funding appears stable, although State & local revenues are most questionable.

TENNESSEE

Anticipate stable funding in FY 1984.

TEXAS

Federal funds will be reduced by 28% in FY 1984, but the State is considering major funding increases (e.g., from current level of $210,000 to request of $10,704,690). Budget may decrease slightly; however, if public inebriate and/or DWI legislation is passed, additional State funds would be made available.

UTAH

Hope for stable funding for treatment, plus $2 million increase for prevention.

VERMONT

Expect to be able to maintain services at current levels.

VIRGINIA

Expect budget increase of 10 to 15% in FY 1984.

WASHINGTON

In FY 1984 expect major State dollar increases & restoration to higher 1982 level. Expect State prevention dollars to double from $850,000 to 1,700,000 and drug outpatient dollars to be restored.

WEST VIRGINIA

Anticipate major State dollar increase ($2.7 million) for shelters & residential treatment (see Supreme Court ruling—item #6) plus expansion of substance abuse prevention & other services.

WISCONSIN

Expect continuing decrease in State monies & services due to $2 billion budget deficit.

WYOMING

Have biennial budget & anticipate 9% inflation increase in FY 1984; don't know about FY 85 (State dollar availability is related to uranium & oil prices).

RÉSUMÉ

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Date of Birth: December 3, 1942.

Place of Birth: Decatur, Illinois.

EDUCATION

University of Illinois, Urbana, Illinois; Bachelor of Arts (BA), with Honors; 1964.

University of Illinois, College of Law, Urbana, Illinois; Juris Doctor (JD); 1966.

Northwestern University, School of Law, Chicago, Illinois; Master of Laws (LLM); 1970.

EMPLOYMENT HISTORY

Executive Director, Illinois Dangerous Drugs Commission, Chicago, Illinois; 1975 to present.

Coordinator, Criminal Justice Programs, Drug Abuse Council, Inc., Washington, D.C.; 1974–1975.

Fellow, Drug Abuse Council, Inc., Washington, D.C.; 1973–1974.

Private Practice of Law and Criminal Justice Consultant, Chicago, Illinois and Washington, D.C.; 1972–1973.

Chief of Operations, Law Enforcement Assistance Administration, United States Department of Justice, Chicago Regional Office; 1971.

Law Enforcement Grants Specialist, LEAA, Office of Law Enforcement Programs, United States Department of Justice, Chicago Regional Office; 1970.

Attorney/Advisor, National Institute of Law Enforcement and Criminal Justice, Law Enforcement Assistance Administration, United States Department of Justice, Washington, D.C.; 1969.

Law Enforcement Consultant, Program Specialist and Executive Assistant to Associate Administrator, Law Enforcement Assistance Administration, United States Department of Justice, Washington, D.C.; 1969.

Legal Advisor, Metropolitan Police Department, St. Louis, Missouri; 1968.

Instructor and Consultant, Law Enforcement Program, North Carolina Community Colleges (Charlotte, Lexington, Gastonia and Rockingham Campuses); 1967–1968.

Legal Advisor, Charlotte Police Department, Charlotte, North Carolina; 1967–1968.

Legal Advisor/Special Investigator, Arlington Heights and Northwest Suburban Police Departments, Arlington Heights, Illinois; 1967.

Deputy Sheriff, Peoria County Sheriff's Office, Peoria, Illinois; 1964–1966.

RELATED PROFESSIONAL EXPERIENCE

Member, National Advisory Council on Drug Abuse, Washington, D.C. (Appointed by HHS Secretary Schweiker, October 1982). (Appointed Secretary and Presiding Officer by NIDA Director Pollin, January, 1983).

Member, National Strategy Council on Drug Abuse, Washington, D.C. (Appointed by President Carter, August, 1980).

Member, Joint Commission on Accreditation of Hospitals (JCAH) Professional and Technical Advisory Committee (PTAC) of the Accreditation Program for Psychiatric Facilities (AP/PF), Chicago, Illinois.

Member, Board of Directors, Legal Action Center, New York, N.Y. (A Public Interest Law Office Advocating the Employment Rights of Recovered Alcoholics and Drug Addicted Persons).

President (Present), First Vice President (1981-83), Vice President for Drug Abuse Issues (1979-80), Chairman of Criminal Justice Committee (1978-79), Chairman of Funding Strategies Committee (1977-78), National Association of State Alcohol and Drug Abuse Directors, Washington, D.C.

Member, Prosecution Function Committee, American Bar Association.

Member, Advisory Task Force, Victim/Witness Advocacy Project, Department of Human Services, City of Chicago, Chicago, Illinois.

Member (Ex Officio and Honorary), Board of Directors, Illinois Alcoholism and Drug Dependence Association, Springfield, Illinois.

Member, Citizens' Advisory Council on Alcoholism, Illinois Department of Mental Health and Developmental Disabilities, Springfield, Illinois.

Member, Informal Steering Committee on Prescription Drug Abuse, American Medical Association.

Commissioned Officer, Food and Drug Administration, Public Health Service, U.S. Department of Health and Human Services.

Adjunct Assistant Professor, Department of Criminal Justice, College of Liberal Arts and Sciences, University of Illinois at Chicago Circle, 1980, 1981.

Member, Narcotics Problems: Policy and Enforcement Committee, Criminal Justice Section, American Bar Association, Washington, D.C., 1977-80.

Member, National Board of Directors, Big Brothers/Big Sisters of America, Philadelphia, Pennsylvania, 1977-78.

Chairman, Prescription Drug Diversion Investigation Unit Policy Board, Chicago, Illinois, 1975-77.

Member, Purchased Care Rate Review Board for State Health and Social Services, Springfield, Illinois, 1975-77.

Member, U.S. Department of Justice Law Enforcement Coordinating Committee, Northern District of Illinois.

PUBLICATIONS

1. Theses

"Eminent Domain: A Study in Intergovernmental Relations," Honors Thesis, 1963, University of Illinois Library.

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2. Articles

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SELECTED PRESENTATIONS

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"SSA Adoption of JCAH Standards", National Association of State Drug Abuse Program Coordinators Annual Meeting, Charleston, South Carolina, June 1977.

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Chairman, "Group Session on Issues Relating to Implementation of Civil Rights of Disabled Persons," Fourth Annual Conference of State and Territorial Alcohol, Drug Abuse and Mental Health Authorities, Washington, D.C., November 1977.

"City/State Relations—Where Do We Intersect?", National Drug Abuse Conference, Seattle, Washington, April 1978.

"Options and Strategies for State Drug Abuse Programming", Fifth Institute on Drugs, Crime and Justice, London, England, July 1978.

Abuse of Dangerous Licit and Illicit Drugs—Psychotropics, Phencyclidine, (PCP), and Talwin (Chicago, Illinois), Hearings Before the Select Committee on Narcotics Abuse and Control, House of Representatives, Ninety-fifth Congress, October 6, 1978, USGPO, 1979, p. 421–426.

"Formulating Rational Drug Abuse Policy: The American and English Responses", Sixth Institute on Drugs, Crime and Justice, London, England, July, 1979.

"The Impact of Standard Setting On The Quality of Care: A Skeptical View", Sixth ADAMHA Annual Conference of State And Territorial Alcohol, Drug Abuse, and Mental Health Authorities, Silver Spring, Maryland, November 1979.

"State Regulation of Prescription Drug Abuse", AMA 6th State Health Legislative Meeting, Phoenix, Arizona, January 1980.

Drug Enforcement Administration Reauthorization, Hearings before the Subcommittee on Health and the Environment of the Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C., March 10, 1980, USGPO, 1980, p. 201–215.

"Prescription Drug Abuse", AMA Auxiliary Leadership Confluence, Chicago, Illinois, October 1980.

"Role of the National Organizations", "Methods of Identification and Problem Solving", 'State Response to the Problem," and "Directions for the Future", White House Conference on Prescription Drug Misuse, Abuse, and Diversion: Strategies for Prevention, Washington D.C. November 1980.

"Cultural Influence on the Drug Abuse Problem in the United States and England". The Seventh Institute on Drugs, Crime and Justice in England, London, England, July, 1981.

"Challenges in Substance Abuse in Illinois", Conference on Substance Abuse in a Changing Society, Governor's State University, Harvey, Illinois, October, 1981.

"Substance Abuse", AMA Auxiliary Leadership Confluence, Chicago, Illinois, October, 1981.

"The Alcohol, Drug Abuse and Mental Health Block Grant: Federal and State Perspective", National Association of State Alcohol and Drug Abuse Directors Annual Meeting, Des Moines, Iowa, June, 1982.

"Federal, State & Local Treatment Resources: Where Have They Gone?", Ninth Annual National TASC Conference, Tampa, Florida, June, 1982.

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[2] Author retains no rights to the manuscript.

"State Issues in Block Grant Funding", 33rd Alcohol and Drug Problems Association of North America Annual Meeting: Growing Together in Changing Times, Washington, DC, September, 1982.

"Financing Issues Affecting Drug Abuse Programs", Alcohol and Drug Problems Association of North America National Conference on Financing Alcoholism and Drug Abuse Treatment Services, February 1983.

SPECIALIZED TRAINING

Institute on Crime, Justice and Heroin in England; American University/University of London.

Illinois General Practice; Illinois Institute for Continuing Legal Education.

Illinois Criminal Practice; Illinois Institute for Continuing Legal Education.

Long Range Planning for the Criminal Justice System Training Seminar; U.S. Department of Justice.

Police Legal Advisor Training Program; Northwestern Unversity School of Law.

OTHER RELATED ORGANIZATIONAL MEMBERSHIPS

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International Narcotic Enforcement Officers Association.
Illinois State Bar Association.
ISBA Criminal Law Section.
Illinois Police Association.
University of Illinois Alumni and Law Alumni Association.
Illinois Academy of Criminology.
Alcohol and Drug Problems Association of North America, Washington, D.C.
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BAR ADMISSION

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United States District Court, 1972.
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REFERENCES

Personal and professional references may be supplied upon request.

Mr. HUGHES. Thank you very much.

Mr. Russo.

Mr. RUSSO. It's a real pleasure for me to present some testimony today on behalf of the great State of New Jersey.

Mr. HUGHES. We're delighted to have you.

Mr. RUSSO. I have to say that, as you know, Mr. Chairman, whenever I go out of State, otherwise the Governor doesn't look upon me very cordially, but it is a great State.

I may make some comments today that may seem somewhat critical of issues and individuals, and I wish those comments be taken in a constructive framework because I think that if I make any critical comments, it's only toward, hopefully, the improvement of what I consider a national tragedy, and that's the substance abuse that all of us are dealing with today.

You have my written testimony in front of you and I surely will not read it, although there are some items that I would like to make known to you. I think in my perspective in New Jersey, and from my association with other colleagues throughout the country, that the problem is extremely critical today, as it was several years ago.

I think the problem, from my perspective, is increasing, while the support for the services, prevention, intervention, rehabilitation, and treatment services is diminishing. For example, if I may just refer to New Jersey, we've had to close the door in the last couple of years and we're treating 6,000 fewer addicts than we were 2 years ago. We're treating 6,000 fewer primarily because of fiscal reductions that we have suffered through a variety of mechanisms from the categorical grants to the block grants and rescissions of formula money, et cetera, et cetera.

We lost approximately $5 million out of our budget a couple of years ago in excess of $20 million, almost 25 percent reduction. We estimate that for every serious drug abuser that we turn away from rehabilitation and treatment and intervention services, we estimate that it's a minimum cost of about $12,000 in terms of criminal activity, law enforcement, medical care, and lost productivity. And that does not include, by the way, the cost of stolen goods.

If you look at the average cost of providing treatment and rehabilitation services in the neighborhood of $2,000 to $2,500, we conservatively estimate that for every dollar that we spend, we save, all of us in society, about $6. That's a very, very substantial, I think, input.

In response to one of the earlier questions, one of the Council members mentioned, yes, we do. There is, I think, a very, very definite cost/benefit ratio in this business that we're in.

In some of my comments, I'd like to refer to some of the previous speakers and I think the Assistant Commissioner of Health, in making his response and in the discussion regarding that they are emphasizing research, epidemiology prevention, and communication, I think that's very critical. I think that's very important. I think we do need leadership in those particular areas, particularly in research and epidemiology from the national level.

There's a peculiar issue, I think, in substance abuse which we don't always realize and I think it was, again, the Assistant Commissioner or the Assistant Secretary who mentioned that if you took money away and put more money into substance abuse services, it may take some money away from cancer research and other things.

While I in no way want to diminish the importance of cancer research or any other research around critical public health issues, however, I think we fail to realize that there is a tremendous amount of research generated around other medical illnesses, by the academic community, and by the industry, the pharmaceutical industry. There's tremendous research generated in those areas because the end product can be very economically feasible. There's very little research in the public sector, in the private industrial sector, around areas in drug abuse, because economically, it's not nearly as feasible as finding a cure for cancer.

That, I think, is very critical so that we need tremendous input from governments in this area, because the private sector, generally speaking, does not fill the vacuum and the need for that kind of research. I think that's something where you have oversight and don't realize that the substance abuse issues in this country, if they're not spearheaded by well-meaning government people like you and I, they don't get spearheaded at all. I think that's unfortunate, but I think it's something we have to realize.

I'd like to refer just to several recommendations that I've made in my written testimony and make a couple commments about those. Then I'll stop my formal discussion.

The demand reduction side of substance abuse issues, I think, needs a much clearer direction. I think it suffers right now from a lack of leadership and national purpose. Now I think the National Institute on Drug Abuse or other lead agency should structure itself into a position to provide national leadership in the development of strategies and policies.

The demand reduction side of substance abuse activities at the State and local level currently flounders and it's in a vacuum, I believe, and it can only get worse if leadership from the Federal Government is not forthcoming. As an example of what I'm talking about, the vacuum in leadership, there was a recent national policy forum in late July in Wisconsin in which a number of private individuals got together, nongovernment people—it was sponsored primarily by private individuals—and at that meeting, the administrator of ADAMHA, Dr. Bud Mayer, made a presentation and he said that the institutes—and he was referring at the point in time—and I'm paraphrasing—the Alcohol and Drug Institutes are primarily involved in research and they do not generate policy. He said at that particular session that policy was generated by Congress.

The White House Policy Advisor, Dr. Carlton Turner, in making a comment, and I'll again paraphrase, in making a comment about that particular think-tank policy meeting in the Midwest in July, did not go there and he essentially said, "Why should I go there? I don't make policy. Policy's made by the President."

Well, here are two leaders in this country, Bud Mayer, Dr. Mayer of ADAMHA, and Carlton Turner, who both say they don't make policy and they both say different agencies or individuals are making policy. I think that's indicative of the field, the drug abuse substance field, right now. I don't see the kind of leadership that we need in this country.

I don't care whether you call the leadership a drug czar or whatever you call it, but we need something in this area.

Another perfect example is the issue of AIDS, which we're all familiar with, probably one of the most devastating public health issues that could affect a large segment of our population. IV drug users are part of the population that are affected by AIDS.

And as you know, as well as I do, there are no individuals who have true diagnoses of AIDS that live. The opportunistic infections get them sooner or later. Its 100-percent death rate when you get AIDS.

When I spoke to the Food and Drug Administration—as an example, again not being totally critical—only in the positive way of hoping to get some change. When I spoke to the Federal Food and Drug Administration about what they thought about AIDS in terms of IV drug users, in terms of methadone treatment, and should we make some adjustments in what we're doing—for example, there's a mandate in the Food and Drug Administration that if you go on the methadone program, you must collect urine samples. Well, urine, along with blood, and along with saliva, are potential carriers of the AIDS agent, whatever that is. And in male urine, there is often semen and semen is supposedly, at this point in time, based on our knowledge, a direct carrier.

I asked the question: Shouldn't we alter our mandates around collection of urine specimens and so forth and so on? The response I got was, "We haven't even thought of that particular issue." It's an extremely critical issue when you have substance abuse treatment programs, and you have IV drug users who are one of the critical populations, along with homosexuals and hemophiliacs, that are coming down with this disease.

Some of the projections, in terms of the prevalence or the incidence of AIDS, is frightening. One small example of a lack of leadership, but I think, gentlemen, we must turn around.

Another recommendation is I think the executive and legislative branches of Government should rely more heavily on what you're doing today. I'm now talking like the minister in church saying to the folks in the audience, you know, "You should come more often, but you're here." I don't believe the legislative and executive branches use the expertise of folks like John and Tom and myself and many, many others in helping to formulate and develop policy in this country.

There's tremendous expertise out there in the field that we did not have 10 or 12 years ago. This industry of ours is only 10 or 12 years old, but today there's tremendous expertise. I don't think governments use the kinds of material and information that are available.

The 1982 Federal strategy should reflect, in my mind, equal emphasis on the demand-reduction side as it does on the supply-reduction side. The Federal strategy does not do that at this point in time. I think that's a shortcoming in the Federal strategy, which I think again reflects a lack of leadership, which maybe reflects a lack of significant awareness on the part of some of our leaders in Washington of the problems that are going on.

The Federal strategy does, as you probably know, recommend or identify abrupt reductions in the level of Federal contributions, for example, the treatment and prevention programs.

It rhetorically says in the Federal strategy, and it seems that the resulting financial shortfall from those reductions will be taken up by State and local governments, in cooperation with the private sector. The limitation of this approach, I think, is compounded, from my perspective, by the assumption in the strategy, very clear, that serious drug abuse, particularly heroin use, is decreasing. That's an assumption that I don't see in New Jersey.

Our heroin use is as high today as it was in 1979. Seventy-eight percent of all the individuals who come in for treatment in New Jersey every year—15,000 of them this year, 21,000 of them 2 years ago when we were adequately funded—78 percent of them come in with a primary drug abuse of heroin. I'm not sure, but I think Jack, from New York, may have similar statistics on the level of heroin use.

I think the national data retrieval system in this country has much to be desired. At present, there is no national data collection system. As bad as the CODAP decline-oriented data acquisition system was, it was a system that did provide the Federal Government with some handle on what's going on.

I don't think the Federal Government right now, since they're not supporting that system, really knows and really has the capacity to respond to how many drug abusers are really receiving treatment. I don't think they have that capacity.

Although some States have developed the MINICODAP system, some have modified it, and some have used their own system. We do not now have, unfortunately, a system that provides you, as policymakers, and other policymakers in the executive branch, the kind of information that I think they should have.

I think there's no assurance at this point in time that this kind of data would be collected, and I think without reliable and valid data, none of us will have the ability to measure the extent of the drug abuse problem, develop strategies to combat that problem, and because of this, I strongly urge, as one State coordinator, that Congress support the reinstitution of a national collection system. I don't care what you call it; whether you call it CODAP or ABC, but I think it's critical, and we don't have that. Again, that's a reflection, ladies and gentlemen, I think, of a lack of clear definitive policy and leadership from the Federal level.

The last thing I would like to say is that I do think, in light of everything that I have said, that we must have increased Federal support for substance abuse services, the whole realm of services. It's cost-effective and it works.

We have an industry out there that has 12 years of experience with tremendously qualified people which we did not have in the late 1960's and early 1970's. We cannot permit that industry to fall apart.

Thank you very much.

[The statement of Mr. Russo follows:]

TESTIMONY BY RICHARD J. RUSSO, M.S.P.H., ASSISTANT COMMISSIONER, ALCOHOL, NARCOTIC AND DRUG ABUSE, NEW JERSEY STATE DEPARTMENT OF HEALTH

My name is Richard J. Russo. I am an Assistant Commissioner of Health in the New Jersey State Department of Health with primary responsibility for New Jersey's Alcohol, Narcotic and Drug Abuse prevention, intervention and treatment activities. On behalf of our Department, I am most pleased to present testimony to your Committee today on what I believe to be one of the most critical social problems currently facing our society. The problem is most critical because while the demand for prevention, intervention and treatment services of drug abusers is increasing, the support for these services by governments is diminishing.

For example, closing the door on opiate using drug addicts seeking treatment is surely not cost effective. In New Jersey, we treat 6,000 fewer addicts today than we did two years ago because of the federal and State budget cutbacks. Every drug user we turn away costs the public approximately $12,000 per year in criminal activity, law enforcement, medical care, lost productivity and so forth. Yet it costs about one fourth that ($3,000 annually) to keep an addict in treatment. It doesn't take a mathematician to realize that these budget cuts have hurt not only addicts who cannot get treatment, but every member of society is paying the price.

THE NATIONAL PERSPECTIVE

A. With the advent of the "New Federalism," there has been a growing shift in responsibility from the federal to the State and local governments. In this period of transition, states are confronted with greater demands and diminished resources. Clearly, this calls for greater planning and coordination of services at the State and local levels as well as a reexamination of priorities. In this current climate of fiscal restraint, the allocation of limited resources must be undertaken in the most cost effective and beneficial manner. Major emphasis must be placed on preventative and intervention services for the more we can do to create healthy children and teach them healthy lifestyles, the better are our chances of having a healthy adult population.

With many traditional societal structures crumbling, high unemployment rates, single parent homes, working mothers and lack of meaningful alternatives, adolescents in particular, are being forced to face the world with few supports to help them through the confusing and often chaotic teenage years. Current national data adequately demonstrates a significant correlation between alcohol and other drug use and abuse among our youth. This is also highlighted by growing rates of absenteeism, vandalism, runaways, and other delinquent behavior and criminal acts.

The problems of drug abuse impact on every sector of our society; whether it be lost productivity at the workplace; accidents on our highways; or disruption of the family unit. Our children are not immune from the problem nor are the elderly. A study sponsored by the Alcohol, Drug Abuse and Mental Health Administration several years ago estimated these costs (drug abuse costs) to have been $65.8 billion, and a recent study by the Congressional Office of Technology Assessment projects that the costs will double for 1983.

This included costs of providing treatment for substance abuse itself, treatment for related medical disorders, lost productivity and criminal justice system costs for drug related crime, among the other factors. It did not include the costs of goods stolen to support a drug habit.

In light of this evidence, it makes sense, in both fiscal and human terms, to invest in an appropriate level of funding for the prevention, intervention and treatment of drug abuse.

In fiscal year 1980 (the base year for the alcohol and drug portion of the ADM Block Grant), federal appropriations for the alcohol and drug abuse project (substance abuse) and formula grant programs totalled $332 million. In fiscal year 1983, this portion of the Block Grant equalled only $222.8 million—a 33% reduction from fiscal year 1980 levels, without adjusting for inflation. If the inflation rates are taken into account, current federal funding levels for substance abuse treatment and prevention services represent a 42% reduction in real dollars since 1980. Indeed, the federal support appears to have been cut nearly in half in the short space of three years.

We applaud the Congress for the supplemental appropriation of $15.2 million for the alcohol and drug portion of the ADM Block Grant included in the recession relief package (P.L. 98-8). However, we must point out that we still need to continue our efforts to combat the ill-effects of unemployment, effects which will continue to place demands on our treatment and prevention systems for years to come. We must realize that with an increased public awareness of drug problems, as well as the recent focus on highway safety issues, the demand for treatment services has increased. I believe we should respectfully request an appropriation of the full authorized level for the fiscal year 1983 ADM Block Grant—$532 million. Although this appropriation would represent a 30% decrease from fiscal year 1980 levels, it would greatly assist the states in continuing a comprehensive treatment and prevention approach to these major societal problems. We urge your Committee's support for the authorized amount of $532 million be appropriated for the federal ADM Block Grant for fiscal year 1984.

B. Two years ago, when it became apparent that NIDA was reducing its support of CODAP (the national client level data system), we had to decide our own future strategy in New Jersey. After considering all the options, we installed MINICODAP, a system designed for State use to be fully compatible with CODAP, thus fostering standardized data.

Our decision to maintain client oriented data was based on our past experience with the usefulness of CODAP. Using CODAP as one of our major data sources, we have developed methods to estimate the incidence and prevalence of drug abuse, and have used these and other data to allocate resources. Most recently, CODAP has been the major source of information for the unfortunate but necessary task of reducing overall funding to drug treatment programs in New Jersey.

The same justification we found for a uniform data system at a State level exist at the federal level as well. In the past, CODAP has played an integral part in policy making within NIDA. For example, combined with data from DAWN, and other sources, it has enabled NIDA to identify and measure the extent of regional and local drug epidemics. This, in turn, has allowed relatively prompt responses at both the federal and State levels.

Today, NIDA no longer has this capability. Only a few states have adopted MINICODAP. Others have developed their own, less sophisticated systems, and others have elected to stop client-oriented collecting data. The federal government is left with a sharply reduced ability to answer even the simplest questions, such as how many drug abusers are receiving treatment.

A unified, national data system requires federal coordination and financial support. Some states don't have the resources to implement and maintain their own systems. Without the ability to use the information, these states have little incentive to collect it. The states must be supported both in the collection of the data and in its use as a policy making tool.

The same situation exists with the National Drug Abuse Treatment Utilization System (NDATUS). This annual, program-oriented system provides data on staffing and funding patterns, and a host of other treatment variables. Again, we in New Jersey have found this to be an important source of information, and again, at the federal level, NDATUS provides the opportunity to measure responses to the problem at local, State and federal levels. NDATUS tells us where resources are being allocated and how they are being used. With the future of NDATUS surveys in question, the ability of NIDA to obtain this timely information is substantially reduced.

The Drug Abuse Warning Network (DAWN) system collects data from a national sample of hospitals and medical examiners on drug related incidents. This system provides important information on the morbidity and mortality of drug abuse. But as it stands, it is not a representative sample. NIDA has developed a strategy for altering the sample to make it representative at a national level, thus improving tremendously its ability to provide usable information. There is now a serious question as to whether NIDA will have the resources to implement this important improvement to the system.

Without the federal support of these systems, there is no assurance that data will be collected at all, let alone in a uniform and usable way. Without reliable and valid data, none of us will have the ability to measure the extent of the drug abuse problem and develop strategies to combat it. Because of this, we strongly urge that Congress support the reinstitution of NIDA's leadership role in supporting these very important systems.

C. Federal Strategy for Prevention of Drug Abuse and Drug Trafficking 1982 assumes and does not question the basic historical policy assumptions that divide drugs into those, such as alcohol and tobacco, legally usable by any adult; those legally usable only if prescribed by a physician; and those legally usable by no one.

Within this historical policy context, Federal Strategy 82 is fundamentally similar to all previous strategies by continuing a model of simultaneously attempting to reduce the supply and demand for illegal drugs. Compared to previous federal strategies, however, 1982 signals a major shift in emphasis to international and domestic interdiction of illegal drug production and distribution, and away from demand reduction through prevention and treatment.

Because the federal strategy attempts to cover most major policy and program issues in the drug abuse field, I want to highlight for you what I consider to be its major weakness from the prospective of a state agency responsible for alcohol and drug abuse prevention and treatment.

This weakness is simply put—the abrupt reduction in the level of federal contribution to prevention and treatment programs, and a rhetorical assumption that the resulting financing shortfall will be assumed by State and local governments in cooperation with the private sector. The limitation of this approach is compounded, from my perspective, by an assumption that serious drug abuse, particularly heroin abuse, is decreasing—an assumption that is simply untrue in the State of New Jersey and I believe in the Northeastern United States as a whole.

The federal strategy documents this financial shift in its own federal budget summary from fiscal year 1980 to fiscal year 1983, while total federal budget outlays for drug law enforcement increased 30% from $537 million to $695 million, budget outlays for drug abuse prevention and treatment decreased by 55% from $459 million to $206 million.

I can assure you that in New Jersey, no combination of new State or local taxes, increased insurance benefits, private sector contributions, or community self-help groups will fill this gap in the time period envisaged by the 1982 federal strategy.

While we in New Jersey support many of the very policy concepts and are indeed working hard to shift the financing structure in directions suggested by the federal strategy, our experience with the abrupt timing of this federal budget shift suggests not an orderly and reasonable change, but a simple abandonment by the Federal government of the prevention and treatment field, and this gentleman is unfortunate.

NEW JERSEY PERSPECTIVE

A. In New Jersey, the 1982 costs of heroin addiction are estimated at approximately $782 million. According to recent data, the approximate cost of providing a full range of treatment services for each client in New Jersey's drug treatment system averages $3,000 per year for an overall cost to New Jersey of approximately $20 million.

Although these estimates are very rough, they provide an indication of the tremendous social costs associatied with heroin addiction.

Given these realities, immediate treatment efforts should not and cannot be abandoned, and concerted emphasis should be placed on the development and implementation of meaningful prevention and intervention activities.

The New Jersey State Department of Health's Division of Narcotic and Drug Abuse Control's funding has been reduced over the past several years by $5,000,000 which reflects a $1,200,000 pre Block federal Grant formula rescission; $3,000,000 reduction resulting from the switch from federal categorical to the ADM Block; and an additional State budget reduction of $800,000. This total $5,000,000 reduction represents approximately a 25% funding loss to New Jersey. The results of this funding reduction over the past two years has reduced the number of treatment agencies from 97 to 80; the annual number of clients receiving substance abuse treatment services from 21,000 in 1980 to 15,000 in 1982; and New Jersey's daily treatment capacity has been reduced from approximately 7,500 to under 6,500. We estimate that for every substance abuser who does not receive treatment, it costs approximately $12,000 per year. With 6,000 fewer treatments in 1982, the additional social cost was approximately $72,000,000. The 20% prevention/intervention mandate under the Alcohol Mini Block Legislation further had a negative impact on the amount of funds available for treatment and rehabilitation services. Unfortunately, during this time of major fiscal reduction, the demand for treatment and rehabilitation services has continued to far exceed our capacity to respond.

We have been able to estimate both prevalence and incidence of heroin abuse, and this information was of the utmost importance in identifying the rapid increase in heroin abuse in Northern New Jersey in recent years. We have also been able to show that recent reductions in treatment admissions (21,000 to 15,000 noted above) are not due to less drug use, but rather a direct result of the reductions in resources available for treatment. In Newark, for instance, we estimate that treatment admissions for heroin abusers are half what they would have been without those reductions. Our data analysis indicates that heroin addiction remains at the same high levels since 1979, while our ability to deal with the problem has drastically diminished.

We have identified a major epidemic in Northern New Jersey—the combined use of glutethimide and codeine. All of our indicators point to its being an extremely serious problem, particularly in Newark, where it is causing as many deaths and emergency room incidents as heroin, and the user population is not the same. "Hits," as they are called on the streets, are being used by a younger population, one which is not involved with heroin.

We have extrapolated data from national and other surveys to provide estimates of the use of other drugs in New Jersey. There are over a half million marijuana and over 100,000 cocaine users in the State. Our data indicates that cocaine and amphetamine use continue to increase at a substantial rate. Although these drugs have been endemic among "street users" for years, their use is increasing at an alarming rate among other social strata. In Atlantic City, for instance, both cocaine and "speed" have assumed epidemic levels of use.

The data we gather on drug abuse problems are continuously analyzed and appropriate responses have been developed. As two examples, we have made methaqualone a Schedule I controlled dangerous susbtance in New Jersey, thus forbidding its sale through legitimate sources and, hopefully, eliminating its abuse in our State. We are now in the process of rescheduling glutethimide as one of our responses to the epidemic in Northern New Jersey.

The National Institute on Drug Abuse has only recently released their 1981 Annual Data Report (Series E, Number 25), which contains two tables allowing us to compare the extent of the heroin problem in New Jersey to other areas of the country. Since heroin is the major focus of treatment efforts nationally, treatment admissions for this drug are a good indicator of the extent of the problem.

The first table reports the percents and counts of admission to treatment for each state (and outlying areas) by primary drug of abuse. Rather than report all states, we have selected the five states with the largest total number of admissions. The table below lists in descending order:

State	Total admissions	Percent heroin	Heroin admissions
California	38,439	46.5	17,874
New York	25,196	54.4	13,707
New Jersey	19,401	78.4	15,210
Pennsylvania	18,911	26.4	4,993
Maryland	11,514	42.4	4,882

There are two important findings from these data reported by NIDA:

New Jersey has the highest percent of heroin admissions of any state. (The District of Columbia, a depressed inner city, has a higher percent, but should not be compared to states.)

New Jersey has the second highest number of heroin admissions of any state. (These data are confounded by the fact that New York does not completely report to NIDA—if they did, we would be third in heroin admissions after California and New York.

The other table lists data for 62 selected Standard Metropolitan Statistical Areas (SMSA's) in the nation. The highest ten SMSA's are listed below in descending order by percent of primary heroin admissions:

SMSA	Total admissions	Percent heroin	Heroin admissions
Jersey City, NJ	778	85.6	666
Newark, NJ	9,729	84.0	8,172
Trenton, NJ	1,203	83.1	1,000
Paterson-Clifton Passaic, NJ	2,764	82.7	2,286
New Haven-West Haven, CT	954	71.6	683
New York, NY-NJ	19,609	67.9	13,315
San Francisco-Oakland, CA	8,788	60.8	5,343
Oxnard-Simi Valley Ventura, CA	1,347	65.1	877
Baltimore, MD	7,304	58.9	4,303
Detroit, MI	8,531	56.9	4,854

These data are compelling in their demonstration of the extent of the heroin problem in New Jersey. The only four New Jersey SMSA's contained in this table are the four highest in percent of heroin admissions in the nation.

It is clear from these data that we continue to have a severe heroin problem in the major urban areas in New Jersey, and that the need for adequate treatment facilities remains an important public health issue.

B. In New Jersey, we expound a behavioral health philosophy that requires that all prevention and intervention activities take into account not only physical and psychological factors but also the social and economic well-being of individuals. Inasmuch as we believe that most problems facing our young people today can be resolved on the community level, we encourage community organizing.

While numerous approaches have been attempted by states and local communities to prevent illegal and socially unacceptable activities from occurring among youth, the majority of the approaches were directed towards drug specific activities.

As part of our State coordinating role, we encourage communities to impact the social ills of today by utilizing the social networks, institutions and settings that significantly influence the development of the youth to be serviced. Within this framework is recognition of the importance of institutions for providing structure in our communities and the potential for using care givers within these institutions to act as change agents. The school, police and local government, (elected officials) are identified because (1) they are permanent institutions found in every community across the nation--urban, suburban and rural, and (2) although these institutions are not the only permanent institutions in the community, they are utilized because of their potential influence on youth, either in a positive or negative way.

The schools are high impact institutions which have the responsibility of preparing youth for full adult responsibility through education and demonstration of model deportment.

The police are identified because any aberration of behavior deportment eventually involves the police, especially if the activities involved are illegal consumption of alcohol or illicit use of drugs.

The local government (elected officials) is utilized because they serve as the representative voice of the community, the nucleus of which is the family.

As a process under the rubric of the Statewide Community Organization Program (SCOP), New Jersey's major primary prevention activity is community organizing. It, (1) builds upon a foundation of coordination of services (networking), and (2) institutional as well as individual cooperation which ultimately leads to social and political change. For it is only through focusing on root causes of problems, rather than symptomatic ills that fundamental change can and will occur.

Over the past three and one-half years, approximately 120 local communities have undergone SCOP training and are, in fact, forming a political constituency in support of preventative services.

This type of constituency is of the utmost importance for it enables both local and State officials to meet the shift in responsibility created out of the New Federalism. Our motto, "Helping Communities Help Themselves," again is reflective of our State's strong desire to keep and maintain a low profile, and to keep State government from imposing and dictating local needs.

SCOP's approach is a low cost, multi-agency, multi-level strategy that focuses on the community and its own resources, rather than on the State or federal government. Thus creating, according to our Governor, Thomas Kean, "a politically viable, locally marketable, program that most any funding agency would smile upon."

Moreover, programs developed and initiated out the these SCOP trained communities have not only been cost effective but were specifically designed by local residents to address their particular community needs.

A recent cost-benefit study of four New Jersey SCOP trained communities (suburban, urban and rural), revealed a savings of over $200,000 as a result of SCOP related activities. Four major types of monetary benefits to the local communities were identified: (1) increases in school attendance, (2) decreases in school vandalism, (3) provision of alternative services for high risk youth, and (4) increased volunteer services. Given these savings, in behooves us to become more involved in such preventative efforts. While New Jersey may well be a forerunner in this approach, other neighboring states are beginning to undertake similar efforts whereby concrete dollar savings can and are being calculated and assessed.

In conclusion, drug abuse remains a very serious health problem in New Jersey, as well as an major social problem. There are nine to 12 million drug related crimes committed each year in New Jersey. Excluding the cost of stolen goods, as I stated earlier, the costs in dollars for heroin abuse alone is estimated to be over $782,000,000 a year in our State. Without substantial improvements in resources to address the problems, we can only look forward to a continuously deteriorating situation.

The State Commissioner of Health and I applaud your Committee for conducting this Hearing and highlighting the public health drug abuse problem. We only hope that as a result of your efforts today, New Jersey citizens will benefit through increased public awareness and increased fiscal support.

Thank you.

RECOMMENDATIONS

(1) The Demand Reduction side of the substance abuse issue needs a clear national direction; it suffers from a lack of national purpose, and a lack of visible leadership.

The National Institute on Drug Abuse or other lead agency should structure its position to provide national leadership in the development of strategies and policies. The Demand Reduction side of substance abuse activities at the state level currently flounders in a vacuum and can only get worse if national leadership in policy development is not forthcoming.

(2) The Executive and Legislative Branches of the federal government should reply more heavily on the tremendous wealth of knowledge and expertise available at the state and local level. Currently, this huge body of knowledge is an untapped resource in the development of national policy and strategy.

(3) The Federal Strategy should reflect equal emphasis in the Demand Reduction side as the 1982 strategy does on the Supply Demand side.

(4) A national data retrieval system capable of collecting data in a uniform, usable manner is essential.

(5) Increased federal appropriations for treatment and rehabilitation Demand Reduction activities proportionate to the increases in the current Supply Reduction national effort.

(6) Increased federal appropriations for prevention/intervention activities not at the expense of treatment or other Demand Reduction activities.

Mr. **Hughes**. Thank you.

Commissioner, we appreciate your contributions. You could have very easily been a witness for us when we were taking up, for purposes of hearing, the so-called drug czar bill. You'd have been an excellent witness for us.

Mr. Gustafson.

Mr. **Gustafson**. Thank you, Mr. Chairman. It's a real pleasure once again to be asked to testify before this distinguished subcommittee. Following the lead of my colleagues, I would also like to abbreviate and summarize my remarks.

Mr. **Hughes**. We appreciate that.

Mr. **Gustafson**. Although I would like to focus my comments on the treatment and prevention aspects of the drug abuse field, I'd like to state up front that I share and underscore the remarks made by my colleagues with respect to a need for a balanced Federal strategy that would address both the supply and demand reduction side.

If you could bear with me just for a moment, I'd like to run through very quickly some statistics which I feel will indicate the enormity of the drug abuse problem in the State of New York. I take issue with many of the statistics and the parameters that were being placed on the problem nationwide by the Federal officials earlier this morning, because quite frankly, that is not what we're seeing in the State of New York, and I don't believe it's the situation in New Jersey and Illinois either.

Mr. **Hughes**. How about among your colleagues in the field? Do they get the same sense?

Mr. **Gustafson**. Well, we were nodding back and forth knowingly to one another and I think I can——

Mr. **Hughes**. I'm talking about throughout the rest of the country, in talking with them.

Mr. **Gustafson**. Certainly in the Northeast corridor, those statistics don't hold water, and I would think so in the central part of the Nation, Illinois, Michigan, also Texas and California. I just don't believe that they're indicative of the magnitude of the problem in some of the areas of the higest incidence and prevalence.

For example, in the State of New York, we estimate there are more than 3 million persons—that's 22 percent of the total State population—that are recent users of both narcotic and nonnarcotic drugs. I would call the subcommittee's attention to the chart on the left-hand side.

Of this amount, more than 1 million, or 10 percent of the population, are regular users. By regular users, I mean people that have used one or more nonnarcotic substances regularly within the previous month.

The overwhelming majority of these people are youths between 18- and 24-years of age. By 1988, we project the total number of regular users to increase by more than 16 percent.

To a large extent, a good proportion of these numbers is directly related to the significant influx of high-quality heroin that began to come into this country in 1979.

Mr. **Sawyer**. When you use the term "nonnarcotic substance," what do you mean?

Mr. **Gustafson**. Those substances that are not derived from an opiate. For example, they would also include prescription drugs, amphetamines, barbituates, anything that's not derived from an opiate such as heroin, morphine.

Mr. **Sawyer**. So that you would—cocaine would be a nonnarcotic substance?

Mr. **Gustafson**. That's correct.

Mr. **Sawyer**. And marijuana also?

Mr. **Gustafson**. Yes.

Mr. **Sawyer**. Hashish and so forth?

Mr. **Gustafson**. Right.

Mr. **Sawyer**. OK, thank you.

Mr. **Gustafson**. Heroin-related emergency rooms, as well as admissions to treatment programs showing heroin as the primary drug of abuse have all continued to escalate. A lot of the attention this morning has been focused on cocaine as a drug of abuse. Well, I can tell you that we have seen in New York State a 300-percent increase in persons entering treatment with cocaine as their primary drug of abuse during the last 2 years.

We recently conducted a survey in the areas around 36 elementary and secondary schools in New York City. At all of those sites, with the exception of one, we found marijuana, heroin, cocaine, and pills to be easily available within 2 blocks of each of those 36 schools.

I think it's really imperative to focus a good part of this discussion on what the impact of the transition from categorical to block grants have meant on the system nationwide. With the implementation of block grants and the reduction of Federal support for human services programs, New York State has suffered a disproportionate reduction in the amount of funds available for drug treatment and prevention services.

For example, in Federal fiscal year 1982, when block grant programs were initiated, the State of New York received $19.1 million. This was a 32-percent decrease from the previous years.

I may add that the State share for drug abuse and treatment activities has always far exceeded that of the Federal Government. In New York State, we have a total program of approximately $150 million, $20 million of that is from Federal sources.

Reductions in support for drug abuse programs are particularly shortsighted given the cost-effectiveness of these programs. That's been proven time and time again. For example, in New York, the average cost to government in direct welfare payment and lost taxes for a single unemployed male substance abuser is over $7,000. The cost of crimes committed by an active heroin abuser not in treatment is estimated to exceed $26,000.

The average costs per arrest and subsequent prosecution total an additional $3,200.

Substance abuse treatment offers an alternative that is considerably less costly to society and offers the opportunity for rehabilitation. The average cost for treatment of a substance abuser in New York State is $2,840 per annum. Without question, this is significantly more cost-effective than having an individual incarcerated in a State or Federal institution.

Congressman Hughes, in your opening remarks, you made mention of the necessity for increased volunteer support and community action throughout the country. We in New York have taken this quite seriously and have organized a group called the Citizen's Alliance to Prevent Drug Abuse, which is made up of all segments of the community, the clergy, business, labor, treatment personnel, and school administration.

They form both an advisory to the State, in terms of developing new and more innovative programs and they also serve as community mobilizers that work throughout the State of New York to motivate citizen participation, create increased awareness, and foster a better environment.

In terms of action that we are asking the subcommittee to take, we certainly would ask you to support, along with your colleagues, the full appropriation of the ADM block grant amount of $532 million. The $439 million, proposed by the administration, would only perpetuate a very bad situation throughout the country. We would ask your good offices to take that into account, and to recommend to your colleagues that they support the full authorized amount.

The other recommendations that were made by Mr. Kirkpatrick and Mr. Russo, I could only underscore. The continuation of the Office of Juvenile Justice and Delinquency Prevention, the establishment of improved Federal coordination through initiation of a drug czar that will have the authority to oversee both the supply and the demand reduction efforts so we don't continue the fragmented, poorly coordinated effort that I believe is in place now.

I'll be pleased to answer any questions that you may have.

[The statement of Mr. Gustafson follows:]

STATEMENT BY JOHN S. GUSTAFSON, NEW YORK DIVISION OF SUBSTANCE ABUSE SERVICES

I am John S. Gustafson, a Deputy Director of the New York State Division of Substance Abuse Services. We appreciate the opportunity to testify before this distinguished Subcommittee. Although my comments this morning will focus upon our substance abuse treatment/prevention system and how we are coping with recent Federal budget and other actions, let me state up front that efforts to reduce both the supply of drugs and demand for drugs must be expanded if we are serious about addressing the drug problem in New York State and across the country.

Our state has the most severe drug problem in the nation. We estimate that more than three million persons (3,289,600—28 percent of the population) are recent abusers of a variety of substances, both illicit and legal, such as cocaine, heroin, marijuana, PCP and pills. Of these recent users, more than one million (1,415,000—10 percent of the population) are regular users of narcotic and non-narcotic drugs. More than three-quarters of a million (793,600—more than five percent of the population) of the regular users are heavy substance abusers. We project the number of non-narcotic abusers will increase by 20 percent by 1986, while the number of narcotic abusers will increase 10 percent.

Over the past five years, we in New York State have been facing the greatest influx of heroin since the late 1960's and the uncontrollable spread of cocaine sales and use. The DEA estimates that 8,000 pounds of heroin are smuggled into the United States annually. Of this amount, one-half enters through Kennedy Airport or New York City's waterfront. The result has been devastating. For example, heroin-related emergency room episodes are up 107 percent since 1979. One-third to one-half of our nation's narcotic abusers are in New York—narcotic abusers in the state numbered 241,500 in early 1982. Currently, heroin admissions account for 72 percent of all admissions to treatment programs in New York City. Unfortunately, we estimate that we are only able to treat 15 percent of the narcotic abusers in need of services.

With regard to cocaine, the problem is running rampant nationwide and particularly in New York State. The DEA estimates 48 tons of cocaine were smuggled into the U.S. in 1982, an increase of eight tons over 1981. A 1981 Household Survey, conducted by the Division, shows that the number of household residents utilizing cocaine and stimulants has tripled since 1976. In the past five years there has been a 300 percent increase in the number of persons entering or seeking treatment for cocaine abuse. Cocaine is truly the new drug of abuse and, without a reduction of supply and financial help for treating those already involved and preventing those from becoming involved, we can only expect the problem to worsen.

Other alarming trends were revealed through a recent Division study on drug trafficking within a two block radius of 36 randomly selected elementary, intermediate, and senior high schools in New York City. Findings, by school type, included:

Elementary schools

There was a progressive increase in the availability of heroin and marijuana, and a continued availability of cocaine and pills, in the areas surrounding these schools. For the first time, hallucinogens such as LSD and PCP were reported available in the areas of two elementary schools.

Intermediate schools

There was an increased availability of cocaine, pills and hallucinogens, and a continued availability of heroin, in the vicinities of these schools. Marijuana activity was found in the areas around all of the intermediate schools.

High schools

Heroin, cocaine, pills and hallucinogens were observed or said to be available in all the areas surrounding these schools. A great deal of marijuana activity was consistently found in all the surveyed high school vicinities.

In responding to the problem, the New York State Division of Substance Abuse Services is guided by a number of basic philosophies, including: (1) Substance abuse is a multi-faceted problem requiring a variety of prevention and treatment strategies and services, and (2) Individual needs can best be served in the community by locally-operated programs, where community resources can be part of the treatment/rehabilitation process. Reflecting these philosophies, the Division funds, supports and monitors a comprehensive statewide network of services which encompasses two major program areas: community-based treatment and rehabilitation services, and community-based prevention services, including school-based programs.

Treatment and rehabilitation services are provided through a system of more than 300 locally-operated programs situated in communities of the state where clients live and work. Community-based treatment programs provide chemotherapy and drug-free services conducted in residential or outpatient settings. Drug-free services include a variety of counseling and therapeutic techniques to assist the client in achieving a productive lifestyle. Chemotherapy services encompass detoxification, methadone maintenance, methadone to abstinence, as well as counseling and other therapeutic services. All treatment programs provide clients with support services— medical, educational and vocational rehabilitation services—either directly or through arrangements with other community resources. The system has the static capacity to provide approximately 47,000 treatment slots defined as the capacity to provide treatment for one person per year. As the system is a dynamic one and the length of treatment varies from person to person, it is estimated that between 75,000–80,000 individuals are being served each year.

As part of the Division's prevention network, we fund and administer over 100 school-based prevention and education programs directed at the state's young people. School-based programs operate in 133 school districts at 957 service sites throughout the state. These programs—which encompass both substance and alcohol abuse prevention—include: educational and informational services; alternative activities, such as peer leadership; intervention services designed to reach children already experiencing difficulties; and activities to improve self-image and decision-making. Approximately 24,000 students receive individual counseling/intervention services, while more than 1.8 million student contacts are made through other components of the school-based prevention programs, such as classroom and assembly presentations.

The Division also funds 48 other programs throughout the state to provide early intervention and other prevention services. These programs, operating in community settings, encompass short and long-term counseling and referral services in addition to traditional prevention and educational activities, such as awareness seminars and literature dissemination. Community-based prevention/intervention efforts enable the Division to annually assist 12,000 individuals who are admitted as primary clients.

In terms of funding, approximately 16 percent of all monies available for local program services—state, Federal and third-party—is used for prevention. When looking strictly at state and Federal direct appropriations, however, 24 percent of these funds are used for prevention. This is due to the fact that prevention programs typically do not receive third-party reimbursements, such as Medicaid, as do treatment programs. Under the Alcohol, Drug Abuse and Mental Health Block Grant, the proportion of total funds used to support prevention services throughout the state has neither increased or decreased dramatically, although we more than meet the 20 percent prevention set-aside requirement under the Block Grant. It is the policy of the Division to share increases/decreases in funding across the entire network.

Important in determining and defining Division policy directions and articulating service priorities and fiscal needs, is our comprehensive data collection, research and evaluation system. The Division has long maintained this capability, regardless of Federal support for such systems. We continuously devote significant time, energy and resources towards identifying the extent of substance abuse, analyzing the social and demographic characteristics of abusers, understanding the effects of drugs on the body system, and determining the effectiveness of substance abuse services. The Division also maintains a special unit to observe and report on current patterns of street drug sales. In addition to regular monitoring of known "copping" areas, surveys have been conducted in New York City's lower Manhattan business district, the garment district, public school areas and video game sites. These surveys not only call attention to the widespread nature of illicit drug traffic, but provide specific information to assist law enforcement efforts.

Supporting our entire program network are our computerized information systems which, among an array of items, enable us to monitor service utilization client demographic characteristics, and the level and frequency of services provided by treatment and prevention programs. These data provide the basis for ongoing management and evaluation reports, feedback reports to local programs to assist them in service delivery and planning efforts, and the Division's program cost-effectiveness analyses.

Despite the existence of a comprehensive network of services, the needs of the people of New York State remain great. Many of our treatment programs are operating at or above capacity: more than 1,000 substance abusers were on waiting lists to enter treatment at the end of August of this year.

With the implementation of block grants and reductions in Federal support for human service programs over the past several years, New York State has suffered a significant and disproportionate cutback in funding for drug treatment and prevention programs. In Federal Fiscal Year 1982 when block grant programs were initiated, the Division received only $19.1 million through the Alcohol, Drug Abuse and Mental Health Block Grant, a 32 percent decrease from the previous year. In fact, the Federal share of fiscal support for drug treatment and prevention has always been very small in comparison to the New York State share. Of the approximately $151 million which supports our entire local service delivery system, only about $20 million annually is received in ADM Block Grant funds. Obviously, the less the Federal Government provided in support of drug treatment and prevention, the more victims and costs there are to be dealt with at the state and local level.

During the first two years of the block grant program, we have been able to reduce the impact on our treatment/prevention system by utilizing funds remaining from previous years' categorical programs, increasing third-party revenue and implementing administrative cost containment policies. We have been forced to cut program funds for certain ancillary services and, in several instances, reduced treatment capacities. Despite our efforts to maintain an effective level of services, we now have a system that is operating at or above 100 percent capacity and have extensive waiting lists, as noted previously. In fact, this situation has existed since 1980, ironically coinciding with the initiation of Federal budget reductions.

Many of the FFY 84 budget proposals now being considered would further aggravate, or at a minimum perpetuate, this unacceptable situation. Even if the full amount authorized for the ADM Block Grant in FFY 1984—$532 million—is appropriated, this would still translate into a 23 percent cutback for drug abuse services from FFY 1980. Adjusted for inflation, the level of decrease would be over 30 percent.

In the law enforcement area, by its own admission, the Administration's "War on Drugs" was a draw in 1982. They report no decline in the overall availability and consumption of illegal drugs, increased quantities of heroin and cocaine, which were purer and cheaper than in past years, and stable marijuana prices. In short, the Administration has spent a great deal of time developing strategies that are ineffective and only serve to fuel jurisdictional disputes that have characterized the drug enforcement effort for years. The illegal drug trade is running rampant in New York State due to the Administration's failure to operate the supply reduction aspects of its Federal Strategy.

Reductions in support for drug abuse programs are particularly short sighted considering the cost-effectiveness of such services. In New York State, the average annual cost to government in direct welfare payment and lost taxes for a single, unemployed male substance abuser is over $7,000. Also, the cost of crimes committed by an active heroin abuser not in treatment is estimated at over $26,000 per year. For those drug-involved offenders that are apprehended, law enforcement costs in the state average $3,200 per arrest, including police, judicial and legal costs. And should the arrestee be incarcerated, the costs per inmate average $19,000 per year.

Substance abuse treatment offers an alternative that is considerably less costly to society and offers the opportunity for rehabilitation. The average cost of treating a heroin addict is only $2,840 per client annually. Prevention services cost even less per person reached.

Without question, government resources alone cannot solve the drug problem: Volunteerism and private sector support are also necessary components of any overall drug program strategy. These aspects have not been overlooked in New York State and, in fact, were initiated by our state prior to the Administration's call for volunteer action as part of the 1982 Federal Strategy for Drug Prevention.

For example, in October 1980, New York convened a statewide group of representatives from the private sector to analyze the heroin problem in the state and make recommendations on how the private sector can be involved in drug abuse prevention. In 1981, we expanded the membership of the group, which was named the Citizens Alliance to Prevent Drug Abuse (CAPDA) to reflect a broadened role in the prevention area. In March 1982, with the assistance of CAPDA, the Division initiated a statewide media campaign entitled "Open Your Eyes" to increase public awareness about the scope of the problem and promote volunteer involvement in local drug prevention and education activities. The campaign, supported in part by corporate financial donations and in-kind services, consists of PSAs, posters, brochures and other printed materials and a toll-free number that individuals can call for information and assistance

For almost three years, we have been providing technical assistance and training to interested parent or community groups in developing effective prevention strategies. We have also produced some informal materials to assist groups in their development. The self-help booklets, entitled "Community Organization Guide: A Framework for Community Involvement in Drug Abuse Prevention" and "Planning and Organizing A Drug Abuse Awareness Event In Your Community", were produced to provide detailed information about organizing community involvement and awareness activities.

The fruits of our labor are beginning to mature. To date, we are working with over 100 volunteer community action groups. These groups have conducted over 600 activities and projects involving more than 110,000 participants. These projects have included, for example: conducting a local survey on drug useage and attitudes; holding a drug abuse awareness meeting for community residents; or organizing recreational activities as alternatives for youth. Our relationship with these local groups is symbiotic—we both learn from each other's experiences, ideas and thoughts. Information sharing is important. The Citizens Alliance to Prevent Drug Abuse Newsletter, which is widely distributed throughout the state and reports on local group activities, contributes to this body of knowledge.

Volunteers are also active with many of our funded community-based drug treatment and prevention programs in helping, for example, to: promote program goals, objectives and services in their communities; conduct fund-raising activites and direct solicitation drives; respond to requests for program information; distribute program literature; and provide office and clerical support.

There are numerous opportunities for business and industry as well, to become involved partners. A few of these are: providing financial contributions and in-kind services to support funded drug program services and local group activities; supporting employee assistance programs; sponsoring drug prevention and education seminars for employees; and encouraging support of community efforts against drug abuse by employees, such as "Executive Loan Programs", as a means of transferring corporate skills and management techniques to local programs and groups.

As one example of corporate involvement, this past spring Grand Union Supermarkets joined our effort by distributing 150,000 drug abuse awareness flyers to customers and displaying anti-drug posters at 164 of their stores. In addition, many of our funded drug programs and volunteer action groups participated by setting up information and literature tables and conducting outreach activities at various store sites.

While volunteerism and private sector involvement are important, let us not disillusion ourselves by thinking that this will compensate for the tremendous loss of Federal dollars and support suffered under implementation of the Block Grants and other actions.

To summarize, we are doing our best with what we have to meet the needs of our residents, in spite of budget reductions and the Federal government's inability to control the supply of illegal drugs in our country. I would like to offer what we consider viable recommendations for Congress and the Administration to enact over the coming weeks:

(1) At a minimum, the $469 million appropriation for the ADM Block Grant should be maintained in FFY 1984. The Administration has suggested reducing this amount—if this is done, it will only worsen an already critical situation. In fact, we strongly urge increased appropriations up to the level authorized for FFY 1984—$532 million.

(2) A Cabinet-level drug policy coordinator position, with the responsibility and authority to oversee all activities conducted by Federal drug enforcement and treatment agencies, should be created. The Administration's response to the drug abuse problem has been a series of single initiatives, indirectly coordinated, with a disproportionate focus on enforcement. This policy fails to recognize that as supply reduction efforts are put into place, the demand for treatment services is increased. Drug treatment/prevention and enforcement must work hand-in-hand. Therfore, we must have a coordinator position to ensure the implementation of a clear, coherent and consistent supply and demand reduction program.

(3) Criminal penalties for drug trafficking, with particular emphasis on strengthening civil and criminal asset forfeiture laws, should be increased. However, the money derived from these laws, which is certain to be in the millions, should not only be used to bolster enforcement efforts, but also to increase Federal support to states for treatment and prevention.

(4) We support establishment of an Office of Justice Assistance that would provide money to states to support a wide range of law enforcement efforts and criminal justice activities, including drug offender programs and alternatives to incarceration.

(5) We also fully support appropriations for the Office of Juvenile Justice and Delinquency Prevention and the youth service-oriented programs they fund. In addition, we urge continued reauthorization of OJJDP next year as a separate program.

I would like to thank you for this opportunity to testify before the Committee and will be glad to answer any questions you may have.

Mr. HUGHES. Thank you.

First of all, Mr. Kirkpatrick, I understand you may have some recommendations relative to the forfeiture provisions of our Comprehensive Drug Penalty Act.

Mr. KIRKPATRICK. That was an additional position of our organization, which is that would believe, although we understand and support the efforts of civil forfeiture provisions to fund law enforcement activities directed at major drug dealers, we also feel that it's not only poetic justice, but a financial necessity for some of that money to be earmarked for the treatment and prevention of drug abuse.

Similar legislation is pending or being proposed in many States, but it is at the Federal level where the largest pots of money are seized.

Mr. HUGHES. Thank you.

Let me just ask, if I might, several questions dealing with the impact of the cuts on the State drug rehabilitation and education, and other programs. First of all, let's begin with you, Mr. Kirkpatrick. In your own State, how many are turned away from the drug program?

Mr. KIRKPATRICK. It's hard to say how many are turned away. We have about an 8-week waiting list to get placed in our programs for hard-core drug dependency. Sometimes that's pushed up as long as 3 months.

Mr. HUGHES. Is that because you don't really keep any data on that?

Mr. KIRKPATRICK. Well, it's because people stop putting their names on the list to get in if there's a 2-month wait to get in. So, all we know is that there are at any given time 20- to 30-percent more people waiting to get in than the programs can hold.

Mr. HUGHES. Are these hard-core addicts, as well as people that——

Mr. KIRKPATRICK. I'd say the biggest gap between available service is in the case of the hard-core heroin addict.

Mr. HUGHES. So these are people that are probably out committing crimes, in most instances to support their habit?

Mr. KIRKPATRICK. Most assuredly.

Mr. HUGHES. They have to wait 8 weeks to get into a program——

Mr. KIRKPATRICK. And, of course, that frustrates the whole idea of getting them into a program to——

Mr. HUGHES. And you're lucky if they're around to go into the program——

Mr. KIRKPATRICK. If they're not in jail by the time they get up, right. Although I have to hand it to the programs themselves, because very often they will squeeze as many possible people into a program as they can, even though they're not getting paid for it, and even though there's really no room.

Mr. HUGHES. Commissioner Russo, you mentioned that we're treating 6,000 fewer substance abusers today than we did 2 years ago?

Mr. RUSSO. In 1980, we were servicing approximately 21,000 individuals who came through the treatment rehabilitation system, and at that point in time, we had a waiting list because we couldn't handle all of them. We don't keep waiting lists any more; it's impossible to maintain waiting lists.

The very nature of serious drug abusers is they need immediate gratification. It's not like you're going to a physician because you have a hangnail and he says, "I'll make an appointment 2 weeks from now; come back." They don't come back. If you can't provide some service immediately in this immediate gratification system we're in, we lose him. We don't maintain waiting lists.

But we're treating 6,000 fewer today. We're down to about 15,000—our projection for the coming year is below 14,000—and the demand is just tremendously high. It's as high today in the State of New Jersey, the demand for services, as it was in 1979.

Mr. HUGHES. I know you don't maintain a waiting list, but do you know offhand, for instance, how long it takes someone who wants help, needs help, to get into a place like Integrity House?

Mr. RUSSO. That's a good example. That place has been filled for years. They've always turned people away. Probably Integrity

House—and I'm just guessing—would probably have a 6-week or so waiting list, time to get in.

Again, that doesn't mean you're going to be able to get in, because they may not be able to find that individual. Things are happening—what Tom mentioned also is that the industry, because of the commitment that people have in the treatment rehabilitation industry, they do things that maybe they shouldn't do; they take more people in than they should. We have counselors now that have a ratio of 60 clients. That's entirely too many for one counselor, but what happens, gentlemen, is the quality of the service is significantly hurt when you continue to take more people in.

But because the industry is so committed, sometimes rather than turn someone away, they provide minimal services rather than——

Mr. HUGHES. Could you give us some idea of approximately how many addicts want help that you can't furnish help to in New Jersey?

Mr. RUSSO. We estimate at least 12,000 people right now. If we had the capacity, we could expand our treatment and rehabilitation effort to handle 12,000 more right now, which would push it back up above 22,000, 23,000 folks a year.

That's a very rough estimate. There's no way of determining that accurately.

Mr. HUGHES. What portion of those, in your judgment, would be heroin addicts?

Mr. RUSSO. Well, as I mentioned before, 78 percent of all the individuals who have come in for treatment since 1979 come in with a primary drug of abuse of opium or heroin, 78 percent.

Mr. HUGHES. We have a very effective TASC program in New Jersey, and in most of the States, it's been a very successful program, one of the success stories on the old LEAA program.

Mr. RUSSO. Right.

Mr. HUGHES. What are we doing today? When a court determines that an individual really requires treatment and goes to TASC, and it is determined that he needs a specialized type of inpatient treatment, what are we doing in those instances where the court has made that determination?

Mr. RUSSO. Very critical and important question. TASC, as you know, is for referral identification of a significant substance abuse problem, to divert someone from the criminal justice system into a treatment system.

Our TASC program in New Jersey really got up and running about the time when the treatment system was closing down. So many, many judges and many, many courts of competent jurisdiction just don't refer any more because there's no place for them to go. It's a catch-22. The system, in identifying and referring individuals from the courts through the TASC project, is working, but the other portion of that system that's supposed to support it and provide those services is so overtaxed that we just can't handle those folks. And there are fewer and fewer people who are referred through there because nothing happens. They're still back on the streets, and they don't get any services.

Mr. HUGHES. Let me see if I can just carry that further. What happens in that situation is that once a drug-dependent offender is before the court, the court has one of several options. First of all, even though the court determines that treatment is the best course, as long as there's no treatment available, the court then is reduced to two options. First of all, cut them loose on probation, which means that they go out into the streets, same environment, and you can expect them back again with additional substance abuse problems; or second of all, incarcerate them at a cost of about four times.

Mr. RUSSO. And you compound that with the tremendous overcrowding in the correctional institutions throughout this country that just can't handle them, so most of those folks go back out on the street, unless they're very serious offenders. The system just can't—the correctional system—at least in New Jersey, and I'm sure many other States—they just can't handle them.

Even with the tremendous increase in the number of correctional beds being developed right now in New Jersey, it's a maxed-out system. There isn't room for folks in that system. Once they get in there, they don't get any services in terms of rehabilitation anyway.

Mr. HUGHES. Mr. Gustafson, you've told us that New York has a serious problem. The extent of the problem, particularly the budget cutbacks. Can you tell us how many addicts, approximately, in New York State right now want help that you can't reach because you just don't have the facilities?

Mr. GUSTAFSON. Dr. Pollin, in his testimony, mentioned that there are approximately 500,000 narcotic addicts in the country; 236,000 of those are in New York State. Of those, we have in treatment at present approximately 30,000. We have a waiting list of 1,000 that are unable to get treatment because there's no space. Strictly narcotic addicts.

Mr. HUGHES. Strictly narcotic addicts. And is that an increase in the number of addicts waiting for treatment over what it was, let's say 1 year ago?

Mr. GUSTAFSON. The trend has been pretty much the same for the last 3 years, given the influx of the high-quality heroin from Southeast Asia. The waiting list figures have remained fairly stagnant at that level of 1,000 to 1,500.

Mr. HUGHES. About what percentage of the people that are on these waiting lists end up in courts while they're waiting?

Mr. GUSTAFSON. Well, let me try to back into that question. The rule of thumb, based on the statistics utilized by the New York State Department of Correctional Services, which currently has incarcerated 32,000 people in State correctional institutions, is that 60 percent-plus of those people are there directly as a result of a drug offense, or drug-related crime, or have a history of drug dependence.

So the vast majority of those people that come through the court systems in New York State are involved with drug offense or have a history of drug dependency and drug involvement.

Mr. HUGHES. OK, thank you.

The gentleman from Michigan.

Mr. SAWYER. Yes. I am just kind of curious. Mr. Kirkpatrick's table here would indicate two States that I just picked out quickly. Maryland and Massachusetts, both of which are rather urban States, both seem to be doing better now with the block grant than they did before. A lot of the others aren't, of course, but why are those two so different?

Mr. **Kirkpatrick**. There are positive sides to the concept of the block grant, which is to support the responsibility with the least amount of restriction at the State level States are doing better in a number of ways, depending on the State. If you can accept for a moment that in nearly every State, that meant a decrease in Federal dollars, but the increased amount of money being spent in prevention, which may be a result of the 20 percent prevention imposition in the ADM block grant, is an improvement.

Prevention is a big problem because it's one of those—the payoffs are so long term and invisible at the present time you're spending the money that it's hard to say you're going to take money away from treating people who are coming in there waiting to get on treatment programs and spend it to prevent that problem, even though everybody agrees it's more cost-effective to do that, it's just that the results are so far down the road and the money is in this year's budget that it's very difficult to do.

That may be a positive effect, that there is more money being spent in prevention, whether it's just a realization that it's a good idea or not. In some States, it has led to the States themselves increasing their own revenues and resources, either by special taxations, earmarked funds or in other ways. But in general, States have had a hard time with the decreased amount of revenues.

Specifically in looking at Maryland and Massachusetts—I should point out one problem. In the transition year from the old categorical grants to the ADM block grants for States, many States experienced what was a windfall in that there categorical grant funds didn't expire for another year and the ADM block grant funds were coming in so they had a double overlap of as much as 11½ months down to maybe 1 month. We were unfortunate in our State; we didn't have an overlap. But that gave the appearance of, for a while, that the resources were adequate. Unfortunately, it will eventually play out in 1983 that there'll be a big gap at the end and that's going to happen even in those States that appear to be flush right now.

Mr. **Sawyer**. I've been kind of interested in the recent period of time, there's suddenly now a lot of professional information that cocaine is physically addicting, whereas up till then, all the information I had was that it was psychologically addicting. I'm not sure I know exactly the difference except they are now saying that there're physical withdrawal symptoms and those kinds of things.

Do you have any view on that?

Mr. **Kirkpatrick**. My view is that I don't really care. Cocaine is as devastating to the person who uses it. Whether you say that it's physically addictive or whether you say it's psycholcgically or whether you say it's dependence-producing, as was pointed out earlier, if a rat will push a button to get cocaine until it starves to death, then I think that's a drug that's got a problem.

The definitions and the research in the area of addiction are very technical. Once they have to identify a molecule that has a receptor side in the brain, et cetera, et cetera, that's where the discussions originally come from about whether it's physically addicting or not. The withdrawal symptom, if that can be proven neurologically to happen, I don't think it makes a difference. I think it distracts us from the real issue, which is that it is a dangerous and debilitating drug which is affecting more and more people.

As Jack Gustafson mentioned, in our State we've had a 400 percent increase in the last 3 years of admissions for use of cocaine treatment. It is the fastest growing. The price is dropping. Price alone used to keep people away from cocaine, young kids, because they couldn't afford it. Well, the price is dropping on cocaine and it's starting to spread. It is a powerful and devastating drug, whether it's physically technically addicting or whether it's purely dependence-producing, however you want to categorize it.

Mr. SAWYER. Mr. Gustafson, you indicated that you didn't believe the statistics that you'd been hearing here. Were those the number of people involved like 5 million cocaine and 20 to 25 million marijuana and 500,000 heroin? Are those——

Mr. GUSTAFSON. Those are certainly part of them. I think part of the problem is that the network by which the Federal Government uses to gather the data is incomplete. They talk about the DAWN system, the Drug Abuse Warning Network. It just targets emergency rooms. All of the emergency rooms in my State are not participating in that program.

We have had a data collection capability in New York State since 1967. It predated the Federal CODAP client-oriented data acquisition process by fully 7 years, so that the data that we have available in terms of the incidence and prevalence of the problem within our State, we feel is much more complete.

I think that the major point that I wanted to make was that I felt that the Federal statistics do not take into account the variation in terms of intensity and types of drug abuse and the impact that it has on a geographic basis.

Mr. SAWYER. When you said that of the 500,000—you used the terms "narcotic users," in the country, you have about 250,000 or something like that; were you indicating by that statement that you thought it was really a lot more than 500,000 in the country?

Mr. GUSTAFSON. No, I think the state of the art is such now that the 500,000 narcotic addict figure is pretty well accepted. We feel that that's an accurate projection of the number of heroin addicts that there are within the country.

Mr. SAWYER. How do you explain that about half of them are in New York State?

Mr. GUSTAFSON. Well, we're not lucky, that's for sure.

Mr. SAWYER. Well, no, I'm not——

Mr. GUSTAFSON. Historically, New York City in particular has been viewed as the heroin mecca of the world. When I say 236,000 in New York State, I should go on to say that 95 percent of those are located in metropolitan New York. The New York City waterfront and its airports continue to be a major importing locale for heroin coming from a variety of sources throughout the world.

In treatment alone, we have, as I mentioned before, over 31,000 narcotic addicts currently receiving care, just the tip of the iceberg. The majority of those are receiving methadone-maintenance treatment, which has proven to be a highly cost-effective and very effective means of treating that particular disability.

Mr. **Sawyer**. You know, I thought that the Miami area and perhaps Chicago area and so forth would have a, you know, proportionately as high a heroin addiction as New York. I'm curious it does not.

Mr. **Kirkpatrick**. If I can, our estimate is that there are a little over 50,000 in Illinois, so you can see that proportionately, it is not as great, even though it's a major metropolitan area.

Mr. **Sawyer**. I know—I was a prosecutor in Michigan—and we used to—and that was several years back obviously—we used to get all the Mexican heroin there that came up, I think, through Chicago. At least that was our general thought. Do you get mostly Mexican heroin in Chicago or——

Mr. **Kirkpatrick**. It depends—we've switched now because there's now a better grade of heroin coming in again from other sources, so our so-called Mexican brown on the downside, but it'll be back. The network is still there. There's a very hard to detect and very hard to break the network between Mexico and Chicago and always will be.

Right now, the market is demanding supplies from other sources.

Mr. **Sawyer**. Well, maybe it's changed in Michigan, too.

I yield back.

Mr. **Hughes**. Thank you.

I wonder if you can describe briefly for us what State efforts are underway for prevention in the schools. Do you have some idea?

Mr. **Gustafson**. Let me take a crack at that first, if I may.

We allocate a considerable portion of our total resources to prevention activities, about $16 million, and a much larger percentage of the block grant moneys were required by Congress to allocate 20 percent. We allocate considerably more than that.

Our prevention programs which are located throughout the State deal with the provision of factual information, generating peer leaders within the schools, providing youth with alternatives in terms of recreational outlets on one side of the spectrum.

On the other side, a good portion of our prevention activities have been directed toward community organization. We're fully cognizant that resources coming from the Federal and State sources are just clearly not enough to deal with the problem. We feel that people at a community level are in the best position to, one, identify what their particular problem is within their community, and with some assistance, to develop strategies that more adequately address what their perception is of the problem.

So we're putting a lot of effort into organizing local citizen action groups. We're encouraging local businesses to participate actively with them.

For example, in New York, we've been able to work very closely with the Grand Union supermarket chain in distributing and producing for us at no cost drug abuse prevention and awareness materials, which they then utilize to distribute through their network of stores. That's just one example.

We have corporations like IBM and others that have made cash and in-kind contributions to our prevention effort. We're putting a lot of energy into working closely with the private sector and with communities in developing very specific responses to problems that are identified at the local level.

Mr. Hughes. Are there categorical grants that are going into the school districts? Is it discretionary money that you have available for these programs for the schools districts? How does the funding mechanism work? How do you encourage school districts to plug into these programs?

Mr. Gustafson. In the case of the city of New York, we have a sum of money which is designated to go through the New York City Board of Education. They in turn underwrite a network of services to provide drug abuse counselors within the schools, prevention materials, educational materials built into the health curriculum, et cetera Outside of New York City, we also deal with a variety of boards of education which engage in very like types of activities.

We don't operate any direct programs ourselves. We are funding and administrative and oversight agencies. We have been out of the direct treatment business now for some years.

Mr. Hughes. How about in New Jersey, Commissioner?

Mr. Russo. As you know, State law almost 10 years ago, mandates a minimum of 10 hours of classroom instruction in all high schools. I think that was a 1973 statute, 1974 statute, through the department of education. That has been going on for a good 10 years.

What we do with the department of education is that we have a very comprehensive teacher-training activity to upgrade the quality and level of knowledge that teachers have. We do not go into the schools ourselves; that's a prerogative of the department of education, but we run continuously teacher education programs.

Another major effort of our prevention is that we believe very strongly in the behaviorial health philosophy that requires prevention and intervention activities, taking into account physical, psychological and social and economic factors. We work very, very closely with communities and we identify communities which, in a big city like Newark, can be a block or a housing development, and in the small town, can be a community.

We tried to identify the basic three or four leaders in every community, and that leader has to be from the political organization, the mayor, has to be from the school system, perhaps the superintendent of the school and from the local government and the police. What we have done, and we have trained—we take these key individuals from the community and/or a block and we take them away for three days to help them identify their needs and to help them identify their resources.

We have taken about 120 communities away and very significant important programs are developing from this concept. Essentially, it's community organization from the textbook. You don't go as a big brother and tell a town what their needs are and their problems are and where their resources are, but you help them to identify by identifying the leadership in that town.

The law enforcement, the schools and the political, the city council, et cetera, et cetera. The institutions that we impact, and it's tremendously—becoming tremendously obvious to us that individual communities, once you give them the opportunity and help them with a little resources—a very little resources—and the only resources, we take them away for three days so they don't get phone calls and we put them up in a hotel. We pay for that, but they have to develop, before they leave that 3-day training session a project that they're going to undertake in their town, a small project, one that's almost going to succeed—not a big project—because success breeds success; failure breeds failure and there've been some tremendously interesting and exciting things happening at the local level.

The community organization, identifying the needs, helping the community to identify their needs and their resources and do something about it, involving the private sector and the parents, et cetera, is critical, and that's our two-facet prevention approach.

Mr. HUGHES. Do you have any programs in the schools that would use young people like Paula and Dean, for instance, to try to relate the direct experiences and insights of those who were drug abusers in a way that students can most fully appreciate.

Mr. RUSSO. Individual substance abuse treatment programs like the program that those two youngsters are involved in do go into the schools periodically. It's not a major emphasis in the State of New Jersey.

Mr. HUGHES. It seems to me it would be a lot more important to have youngsters who've been through it. They can relate a lot more to students than I can to tell the dangers. When the police tell them the dangers of drug abuse, or even a teacher telling them the danger of drug abuse, much of the credibility and effectiveness of the impact may be missing.

Mr. RUSSO. Years ago, and I can relate back to 10 years or so ago, there was a major emphasis of parading in front of large school audiences exdrug users, and maybe at that point in time, we didn't know as much as we do now, and I think we may have hurt the situation in some cases. In many cases, when a previous substance abuser told about his or her experiences and how bad they were, and yet that individual made it and now that individual is standing up before an audience of 500 youngsters in the high school, it stimulated the appetites.

We did some surveys. It stimulated the appetites of some individuals in that school who weren't sure whether they should use drugs or not, because here was an opportunity or perhaps a way of becoming recognized. It's a double-edged sword unless it's done effectively. The two youngsters today probably could do it very, very effectively.

Mr. HUGHES. I haven't seen any studies, any surveys, but I can tell you that they don't need anything to stimulate their appetite. If anything, I think the cutting edge is the other way.

Mr. RUSSO. I think if you could identify——

Mr. HUGHES. You could have some people in there and tell them, you know, exactly what it's done to their life.

Mr. RUSSO. If you could select the individuals—and those two folks today would do an excellent job—I think it's an excellent program.

Mr. HUGHES. Well, as I say, I'm not an expert, but I would bet—I would chance putting a youngster like Dean or Paula in the school to share their experience with them, not before 500 students, perhaps smaller classes, and I think that would be far more effective than the chief of police going in, as it happens in my community, or the superintendent of public schools going in and telling them how bad drugs are, you know, which is just a joke.

Mr. Russo. There's no question.

Mr. Gustafson. Mr. Chairman, if I could piggyback on Dick Russo's comment. The same way that—I think the gentleman Dean was explaining that in school, when he was receiving some information relative to drug abuse, it kind of whetted his appetite and it made him a little bit curious as to what the effects would be.

We have found, back in the late 1960's and early 1970's, when we brought into a school situation people that were involved, say, with heroin—teenagers, 15, 16 years old, and they recounted their stories about making $6,000 to $7,000 a week in the trafficking; or they were engaged in prostitution to support their habit and were living in Park Avenue suites, that fostered a lot of permature experimentation on kids that probably would not have gotten involved.

We've gotten away from that approach. I would fully endorse a presentation and utilizing individuals like the two young people who testified before. The experience in the past, though, has not proven that to be effective in utilizing some of the people who are actively engaged in the trafficking aspects.

Mr. Russo. I think what's critical, sir, in what you're referring to is that peer pressure turns youngsters on; proper peer pressure can help to turn youngsters off. I think that's the important thing, if you can identify the individuals who are going to present that peer pressure. It is important, and it is productive if you can identify those folks. It's that peer pressure, whether turning them off, just like they were turned on with peer pressure, is critical and extremely difficult to control, however.

Mr. Hughes. OK, thank you

Thank you very much. There are some encouraging signs that we recognize that we don't have a Federal strategy. We need somebody to be in charge at the top. That's a step in the right direction. We found out very clearly, if we want to convince the South Americans that they should do something, we've got to start doing something ourselves back here at home, because our failure to commit resources to drug rehabilitation and education in our country undercuts our efforts in South America and other places.

That's the first question they ask: What are you doing about the problem in your own country? It's a tough one to answer.

Mr. Gustafson. We couldn't sum it up any better.

Mr. Hughes. Thank you very much. We appreciate the contributions you've made.

Our final panel—and we apologize for the lateness of the hour, we've really gone over today—consists of Dr. Anderson Johnson, Mrs. Sue Rusche, and Dr. Mel J. Riddile.

Dr. Johnson is both the director of the Health Behavior Research Institute and the associate director for cancer control research at the Comprehensive Cancer Center at the University of Southern California. He's a licensed psychologist and has had a distinguished career at Duke University, at the University of Minnesota and at the National Bureau of Standards.

He has served on numerous public and scientific committees and boards, and has been sought as a consultant on numerous public health issues.

The second member of our panel is Mrs. Sue Rusche. Mrs. Rusche is executive director of Families in Action in De Kalb County, GA. She is also the secretary of the National Federation of Parents for Drug-Free Youth, which is holding its second annual conference here in Washington on Monday and Tuesday.

Mrs. Rusche was a leader in the movement of parents that has brought about bans on the sale of drug-related paraphernalia in most States. She is now writing a syndicated column for parents on drug abuse prevention issues.

The third member of the panel is Dr. Mel Riddile. Dr. Riddile is the director of Straight, Inc., for greater Washington. We understand it is related to the Florida facility.

Prior to joining Straight, he was the coordinator for substance-abuse prevention in the Fairfax County, VA, school system, and served as executive director of the Northern Virginia Action Coalition, a committee of business and civic leaders that developed a legislative package for the Virginia Assembly on issues such as the drinking age, drug paraphernalia and look-alike drugs.

Dr. Riddile has had over 10 years of experience in the Fairfax school system as a teacher, counselor and administrator. He's written numerous articles on drug abuse.

We are delighted to have you, Dr. Riddile, and the other members of the panel with us today. We have your statements which, without objection, will be made a part of the record in full, and we hope you can summarize.

Why don't we begin with you, Dr. Johnson.

TESTIMONIES OF DR. C. ANDERSON JOHNSON, DIRECTOR, HEALTH BEHAVIOR RESEARCH INSTITUTE, UNIVERSITY OF SOUTHERN CALIFORNIA; SUE RUSCHE, EXECUTIVE DIRECTOR, FAMILIES IN ACTION, ATLANTA, GA, AND SECRETARY, NATIONAL FEDERATION OF PARENTS FOR DRUG FREE YOUTH; AND DR. MEL J. RIDDILE, DIRECTOR, STRAIGHT, INC., GREATER WASHINGTON

Dr. JOHNSON. Thank you, Mr. Chairman. I will attempt to summarize.

To emphasize the major points, there are three points that I would like to make, the second of which I will develop in some detail.

The first point is that I would like to place some emphasis on the rationale for prevention. The second point is I'd like to summarize for the committee data that support the feasibility and the promise for prevention now. Third, I'd like to say something about what appears to be reasonable directions to proceed at this point.

For several reasons, the prevention of drug abuse is preferable, when possible, to reactive treatment of drug abuse disorders. First, the success rates for drug abuse treatments, while improving, tend to be low. Second, drug abuse treatment programs, as we've heard today, although it's not emphasized, tend to be expensive. Third, and I think most importantly, is typically drug abuse treatment programs or interventions come too late. Tremendous costs to both the individual and the society have already occurred by the time the person enters into the treatment.

I do not mean to devalue the place of treatment in drug abuse control, but it is important to consider the potential for prevention in overcoming these three limitations of treatment.

There is now good reason to believe that drug abuse can be prevented. There are now a dozen or more studies conducted in different regions of the country, with different populations, by different researchers, establishing the efficacy of particular social-psychological interventions for preventing cigarette smoking. All of these successful prevention programs have emphasized training and peer pressure resistance skills, or how to say no to offers to smoke, and have mobilized significant peer group support for the prevention program.

I would like to describe examples from our own research of the effectiveness of these programs. The original Robbinsdale, MN, antismoking project tested the social pressures, sensitization, resistance skills training program, with and without peer leader mediation. The results, over a 32-month period, I will present.

Let me say briefly what happened. There were three experimental schools. In one school, there was a program designed to teach young people, sixth and seventh graders, skills in resisting pressures, social influences. We've heard testimony about how important social examples influences are.

In another school, that same approach was used, only now peer leaders were identified from the classroom, brought out of the classroom, trained at the university. They went back into the classroom and helped us implement the program. The third school was a control school.

Could I have the first slide, please.

[Figure 1, prepared statement, smoking index.]

Dr. Johnson. The first slide presents results over a 3-year period, beginning at seventh grade in this study. Seventh grade—what is depicted here on the left side is the pre-measure in October 1977. This represents cigarettes per student per week. That's what this measure is.

The middle curve, the X, is for the children in the schools that did not receive treatment programs. The top line represents the school that received the interventions without peer leadership identification and training and mobilization.

The bottom curve in the onset curve, cigarette-smoking onset curve, in the school where the peer leaders were identified and mobilized.

There were only five 1-hour sessions between the months of October and May of 1977–1978. We got immediate treatment effects, as is obvious, we expected no lasting effects until the following year. We thought that it would require booster treatments in subsequent years. At the end of eighth grade, the program effects were still there.

We decided at that point not to do boosters and see how far we could go with the effect. At the end of the ninth grade, we still had a treatment effect, although in the treatment school at the bottom, there was a significant onset. It was still considerably less. There was still considerably less smoking than in the other schools.

In the spring, we collected data at 12th grade as the students were graduating. I don't have those data analyzed to present to you today.

The second study in the Minnesota series provided a replication of this. We found the same effects under somewhat more tightly controlled studies, now multiple schools assigned to each treatment condition. [Figure 2]

Simultaneously, a study was occurring at Stanford, by McAlister, Maccoby, Perry. They did peer leader interventions alone. They got results of the same magnitude. The same pattern of results has been replicated at Cornell and others.

In a third study, we decided to see how well these programs would translate when implemented by teachers. We found that teacher-led programs clearly were not as effective in their effects, as were programs that involved, again, peer leaders.

Beginning in 1980, we began to test the generalizability of this approach to an older population. We now tried interventions with 10th graders, assuming this was a population that had already begun to smoke some cigarettes to a large extent, but perhaps we could have some impact still at that stage. That proved not to be the case.

[Figure 4, prepared statement.]

Dr. Johnson. This gives you an idea of the onset of cigarette smoking from fall of sixth grade—these are the percentages of people who were smoking one or more cigarettes per day. Fall of sixth grade, spring of seventh grade, fall of seventh grade, spring of seventh grade and fall and spring of 10th grade, spring of 11th grade and spring of 12th grade.

What you see there is that prior to sixth grade, or at the beginning of sixth grade, there was very little cigarette smoking. The onset was very rapid between sixth and seventh grade. By 10th grade, it appeared that the maximal proportion had begun to smoke and the curve was flat from there on.

So it's not too surprising that 10th grade interventions were too late. It's an important point, though, interventions must come early.

We have extended this approach now to the use of mass media, the use of mass media in conjunction with school programs primarily to reach whole families, not just children in school. We're concerned about doing that because of the tremendous effect that the family has on the child, the tremendous influence the family has.

Could I see the next slide, please.

[Slide.]

I'm sorry—it's the one that is outside the frame, please.

[Slide.]

Yes. This slide is a little bit complex. Let me point out the major point. This shows the effects of school-based and media-based prevention and smoking cessation programs.

There was 1 week, 5 days per week, in which children received the in-school prevention program. At night, there was televised, via KABC television in Los Angeles, Dr. Art Ulene delivering it, a 5-minute segment that coincided with the day's activities.

Parents were recruited to watch the segment with their children and then participate in some homework activities with the children. During that week, smoking parents were encouraged to come around for a second week and participate in a smoking cessation series. Again, five consecutive nights, 5-minute segments.

This shows something about the improvement rate. This (columns labeled P/T) is in schools where we were doing the program. I will ignore this (columns labeled P/NT), these were schools that fell somewhere in between. These were control schools (columns labeled C).

Fifty-one percent of smoking parents did stay around and watch one or more of the cessation segments, compared to 13 percent of control schools, where there was not an ongoing school program. Thirty-eight percent tried to stop smoking, compared to 15 percent ultimately in the control schools.

At 1 month, 19 percent of smoking parents of children in treatment schools had stopped smoking compared to 5 percent in the control school.

At 1 year—we just have one-year data that we've looked at—in 1 year the successful cessation rate among smoking parents of children in the treatment schools was 18 percent, compared to 5 percent of the original quitters, but we had 6 more percent quit that year so it's really 18 percent compared to 11 percent.

We're encouraged by these results that mass media can be used in conjuntion with school programs. This is a step toward a coordinated community effort involving parents and families, as well as the school system.

Let me say a word about what characterizes the successful prevention programs and makes them different from previous unsuccessful smoking and drug education programs. First, there is a focus on short-term, particularly social consequences of smoking. It was pointed out today by the two young people who testified how important social influences are. Peer examples and the need in adolescence, especially early adolescence, to be accepted by peers. It's a very important driving, motivating force at that time in the developmental span.

Second, there is sensitization of the audience to the overt and covert pressures to smoke, both peer pressures and media pressures and adult pressures. Third, there is the active teaching of social resistance skills, providing the young people with skills in how to say "no," and not feel rejected when they do that.

It's easy for us—or we think it's easy for us to do that; for a young person, it sometimes is very difficult. We do that by providing role models; peer leaders demonstrate these skills, the whole set of skills; students practice this in the classroom; they are reinforced systematically for practicing those skills.

Fourth, there's the active involvement of peer leaders, as I described earlier, in implementing the program.

To summarize, the recent research in smoking prevention has provided a number of replications which, when taken together, strongly confirm that prevention of cigarette smoking onset in adolescence is feasible, especially in early adolescence.

There are several reasons to be optimistic that the proven approaches to smoking can be useful for the prevention of other substance abuse as well. First, the predictors of cigarette smoking and alcohol and marijuana use—these drugs are thought of as the "gateway" drugs. Very few people enter into harder drug use without first being exposed significantly to one or more of these drugs.

The predictors of the use of these three substances are the same, that is, in the vast majority of studies, the strongest predictors are peer use, especially close friend use; parental use; and rebelliousness tendencies and risk-taking tendencies.

Second, cigarette smoking is a risk factor for the onset of alcohol and marijuana use. I'm going to present data now from our 10-grade study where we were unsuccessful in affecting cigarette smoking.

[Figure 7, prepared testimony.]

Dr. JOHNSON. This is an epidemiologist's approach to risk factor analysis. That is, what is the risk that a nonalcohol user, a person who is not using alcohol in January of 10-grade, will start using alcohol by the end of 10-grade? That's the question that's asked here.

Given, in the no-risk situation, the bar on the left, that at mid-10-grade, he's not smoking cigarettes, and he's not using marijuana. If the person was not smoking cigarettes and not using marijuana and not using alcohol, he had a 28 percent chance of beginning to use alcohol by the end of the year.

If the person, however, was already smoking cigarettes, but not using alcohol and not using marijuana, there was a 58-percent chance that he'd start using alcohol by the end of the year.

If the person was using marijuana alone, there was a 54-percent chance he'd start using alcohol by the end of the year, and if the person was using both cigarettes and marijuana, there was a 75 percent chance that he'd start using alcohol by the end of the year. So clearly, cigarette smoking and marijuana use are risk factors to the onset of alcohol use; cigarette smoking is at least as strong a risk factor as is marijuana.

Next slide, please.

[Figure 6, prepared statement.]

Dr. JOHNSON. The same kind of analysis is presented here for marijuana transitions: What is the probability that a nonmarijuana user will start using marijuana above the 10-grade year? If the person was not smoking cigarettes and not using alcohol, there was an 11-percent chance he'd start using marijuana.

If he was using cigarettes alone, there was a 27-percent chance. If he was using alcohol alone, there was a 20-percent change, and if he was using both cigarettes and alcohol, there was a 43-percent chance.

So, again, these two "gateway" drugs, cigarettes and alcohol, are risk factors to the onset of marijuana use.

Just briefly for you to look at, and I won't say anything about it, it does turn out that marijuana and alcohol—marijuana is a risk factor to the onset of tobacco use; alcohol may not be, at least at 10-grade.

It is clear from these analyses that cigarette smoking, alcohol use, and marijuana use, each can act as "gateway" drugs for the onset of the others, with the possible exception that alcohol use may not increase the risk of the onset of cigarette smoking.

The importance of tobacco use as a risk factor for onset of other drug use suggests the possibility that preventing tobacco use may indirectly minimize risk to other drug use.

I'd like to move now into briefly summarizing recent evidence where the same prevention strategies that have been used for preventing cigarette smoking are being used successfully for preventing alcohol and marijuana use onset.

First, there was a study by McAlister and his group at Stanford where they found that just devoting one of five sessions to alcohol and marijuana use, using the same strategies I've described did result at 1 year in a decreased onset rate of alcohol and marijuana use.

In our 10-grade study, where we paid no attention at all to alcohol and marijuana, only intervened in regard to cigarettes, we found at 1 year significantly less marijuana use in the treated group than in the controlled groups.

There was one caution that was raised by that. In fact, the most marijuana use onset was found in schools where there were teacher-led programs that did not involve peer leadership.

More recently, and yet to be published—it's in preparations of study by Botkin at Cornell where he's found that a program designed specifically for drug abuse prevention was, indeed, successful in preventing at 1 year alcohol and marijuana use, as well as cigarette use.

This morning, Secretary Brandt mentioned that I would describe briefly a NIDA-funded drug abuse prevention program which is called Project SMART. I had not planned to do that. I will only say there is such an effort underway in Los Angeles right now that is now being extended to be a communitywide effort involving television, involving Orange County as well as Los Angeles County school systems, involving the Scott Newman Foundation, family orientation, and so forth.

In brief summary, I would say that my reading of the advancements in the field over the last 6 years, these advancements are significant. There's consistent promise that cigarette smoking, and now alcohol and marijuana use, can be prevented with cost-effective interventions—relatively low-cost interventions. I think standardization of these interventions is very important when we talk about defusing programs. I think there needs to be standards of prevention practice, just as there are for treatment practice.

[The statement of Dr. Johnson follows:]

STATEMENT OF C. ANDERSON JOHNSON, PH.D., HEALTH BEHAVIOR RESEARCH INSTITUTE, UNIVERSITY OF SOUTHERN CALIFORNIA

The efficacy of a school based, social psychological approach to primary prevention of cigarette smoking is now well established. The effects have been replicated by independent researchers at a number of different sites with quite different populations, and appear to be durable over time. Until this recent series of studies there were little or not empirical data to support that cigarette smoking or other drug abuse in adolescence is preventable. The successful demonstration of primary prevention in the area of cigarette smoking offers promise that similar techniques may be useful in preventing the onset of alcohol, marijuana and other drug abuse as well. Additional research on associations among Various types of drug use, cigarette smoking as a risk factor-for other drug use, and effects of experimental prevention programs on marijuana and alcohol use further suggest the promise of social psychological intervention for primary prevention of drug abuse.

RESEARCH IN CIGARETTE SMOKING PREVENTION

In 1974, there began a series of investigations, first at the University of Houston by Richard Evans and his colleagues, then at Minnesota by Johnson and Luepker and their colleagues, and Standford by McAlister, Maccoby, Perry, and their colleagues that established the efficacy of a social psychological approach to prevention of cigarette smoking in adolescene. These studies were similar in that they all were based on laboratory findings and theory from experimental social psychology, they all treated the onset of smoking as a socially mediated phenmenon, they relied on social interventions to bring about changes in developmental trends regarding smoking, and they measured vigorously with multiple measurement techniques the effects of experimental programs on smoking incidence rates. I will review here briefly the consistent line of evidence from those three laboratories and elsewhere that supports the robustness of this approach to prevention of cigarette smoking, and then will review data that suggest that other drug abuse may be preventable in the same way.

In 1977, Evans, et al., reported an innovative approach to cigarette smoking for junior high school students. In that approach Evans, et al., applied several important findings from social psychology to primary prevention and to measurement of behavioral outcomes. They developed a series of three films to be shown in the classroom. Those films were designed 1) to heighten students awareness of social pressures that influence adolescents to start smoking, including peer, family, and media influences; 2) to suggest that resisting those pressures in both feasible and socially acceptable, and 3) to provide psychological innoculation to presuasion by giving students a sampling of pro-smoking arguments they were likely to encounter and counter-arguments that could be useful in resisting those temptations. In addition, Evans applied to the measurement of smoking behavior the "bogus pipeline" approach to attitudinal measurement developed by Jones and Sigall (1971). The rationale of this measurement technique is that self reports of smoking behavior will be more accurate if respondents know or believe that an independent biological assessment is being made as well.

That study and those which have followed, using the Houston model of a largely film-mediated approach, demonstrated an apparent "program plus measurement" effect. That is, the film program together with the "bogus pipeline" measurement reduced the onset of cigarette smoking by about 50%. However, no independent program effect was demonstrated in those studies. There was no significant difference between the group that received the films plus the bogus pipeline measurement procedure and those who received the bogus pipeline measurement alone. Nevertheless, this was an important study suggesting for the first time that prevention of cigarette smoking in youth is possible and providing the outline of a plausible approach to smoking prevention.

Shortly thereafter in a series of studies beginning at Stanford and Minnesota and continuing at Harvard and USC, respectively; McAlister et al., and Johnson et al., repectively, took the social psychological approach several steps further.

In addition to sensitizing students to overt and covert influences to smoke, both the Stanford-Harvard and the Minnesota-USC groups introduced active resistance skills training into the curriculum. These smoking prevention programs, which became required curricula for all 7th grade students in participating schools, included not only role model presentations of resistant behaviors, but also required students to generate in classroom activities a strong rationale not to smoke and to develop through role playing sessions the skills necessary to resist social and media influences to smoke. Both groups also introduced a second social psychological intervention, the use of peer leaders to help deliver the prevention program. In the Stanford studies peer leaders were persons about 2 years older than the target population who were selected for their socially desirable characteristics, trained as peer leaders and then brought into the classroom to implement phases of the program. The Minnesota group, working independently of the Stanford group, developed a different peer leader approach wherein naturally existing peer leaders from within target classrooms were identified sociometrically, recruited, and trained to assist in program implementation.

McAlister et al., (1980) reported that whereas smoking prevalence was about 3% and 2% at baseline in treatment and control schools, respectively, at the end of 7th grade almost 10% were smoking at least weekly in the treatment school and about 5% in the control school. Follow-up measures taken one year later at the end of 8th grade indicated that weekly smoking was 16.2% in the control school and 5.6% in the treatment school. These results taken together with similar findings at Minnesota are exciting.

The Minnesota-USC studies provided reassurance that the apparent treatment effects in the Stanford study were not the result of differential attrition rates. They provide experimental data as well about how the various social psychological and behavioral program components contribute to the overall effect. Three studies, two at Minnesota and one at the University of Southern California, have tested and continue to test the prevention effectiveness of various social psychological and behavioral intervention components drawn primarily from social learning theory, causal attribution theory, and attitude change research. The original Robbinsdale Anti-Smoking Project (RASP) tested a social pressures sensitization and resistance skills training program with and without peer leader mediation. The results over a 32 month period are depicted in Figure 1 (Luepker, Johnson, Murray et al., 1983). Analyses included only those persons who were present at the premeasure and at least one of the three post measures (previous studies reported prevalence rates without controlling for attrition). At the end of the 7th grade (May 1978), students in the peer mediated social pressures condition were more than twice as likely to report weekly smoking if self reports followed saliva collection than if not. Apparently students under report smoking behaviour under some conditions, and awareness of a separate biological measure increases the tendence to report smoking behavior. Evans, et al., (1977) reported similar findings. These data are consistent with findings reported elsewhere (Bickman, 1972; Deutscher, 1973; Wicker, 1969; and Geller, 1981) indicating that self reports of behavior are sometimes less than veridical. On the basis of our early findings and subsequent research we have raised questions about the veridicality of longitudinal findings in the absence of a biological measure, especially where there is the possibililty that self report biases are changing (Johnson, 1981, Murray, et al., 1982, and Mittelmark, et al., 1982). Figures 2 and 3 show that our data and those of Perry, et al., do not support the findings of Green, et al. (1979) and Johnson, et al., (1982) that cigarette smoking is declining in youth. One interpretation is that self report biases are increasing, an interpretation that is supported by the decline observed in Minneapolis students' estimates of the numbers of persons who smoke.

The seond study in the Minnesota series provided our first replication of RASP from a somewhat stronger quasi-experimental design. In this study eight schools were stratified on the basis of smoking prevalence at beginning of 7th grade, and one of the high smoking schools and one of the low smoking schools were assigned to each of four experimental conditions; a peer led social condition with videotaped stimulus materials, a peer led social condition without taped stimulus materials, an adult led social program with video materials, and an adult led health program which emphasized the long term health consequences of smoking. Consistent with findings from the RASP study, the peer led social programs were the most effective in preventing smoking onset over a 20 month period, even though no differential effects were seen at the end of eight months. Flay and Best (1982) also have reported delayed effects where the smoking prevalence and incidence rates are initially low.

The second phase of the second study permitted us to test the power of the experimental interventions when implemented by classroom teachers rather than highly skilled project staff. There was some question about whether program effects could be replicated under these more stringent conditions. In that study health educators from each of the participating schools were trained to deliver one of the four experimental programs. As in the previous year schools were stratified according to baseline smoking and assigned randomly from within strata to one of the experimental interventions. At the end of the intervention year students in the peer-led social skills schools were smoking significantly less than those in the other schools. No baseline differences were noted. Again, the peer led social program was the most effective (Murray, Johnson, et al., 1983).

It may be that the timing of interventions is crucial. Interventions at 6th grade (ages 10-12) and 7th grade have been consistently effective in preventing onset of smoking. These same interventions applied in mid-adolescence (ages 14-16) may come too late to prevent cigarette smoking. Beginning in 1980 we sought to test the generalizability of the social psychological prevention model to an older population of 10th grade students in Los Angeles County. Figure 4 shows that between the fall measure in 10th grade and the end of 12th grade there was little additional onset of smoking in this population. Given the low onset rate it is not surprising that no prevention effects were found. The effects of interventions at immediate post test were not significant although they were in the predicted direction with means for social programs appearing lower than health and control programs. At one and two-year followup there were still no apparent treatment effects.

The USC group recently has combined school based prevention programs with broadcast television to reach whole families as well as students. Five-minute clips coinciding with a classroom smoking prevention program were broadcast on five consecutive nights via KABC-TV, Los Angeles (Flay, Hansen, Johnson and Sobel, 1983). Parents were recruited to participate with their children in homework assignments using the television broadcast and written materials. Smoking parents were also recruited via the broadcast to participate in a five-part smoking cessation sequence the following week. One year followup measures indicated that the onset of smoking among students in the school-television prevention program was less than one half that in control schools, consistent with previous studies. Figure 5 shows that in addition, the program was effective in eleciting and maintaining cessation among smoking parents of children in participating schools (18%) compared to parents of children in control schools (11%). Among parents who watched one or more cessation sessions, the one-year quit rate was 38%.

To summarize, the recent research in smoking prevention has produced a number of replications which taken together strongly confirm that prevention of cigarette smoking onset in adolescence is feasible in early adolescence. The findings may be summarized as follows:

1. The onset of cigarette smoking in preadolescence and early adolescence (grades 6 and 7, ages 10–13) has been reduced 50–75% consistently in a number of studies (Hurd, Johnson et al., 1981; Luepker, Johnson et al., 1982; McAlister, Perry et al., 1980; Botvin et al., 1981; and Flay and Best, 1982).

2. The successful prevention programs share a number of common elements, including: a focus on short term, primarily social, consequences of smoking; sensitization of the audience to overt and covert pressures to smoke; attempts to innoculate persons attitudinally to those influences; a Socratic approach to learning, modeled resistance skills; practice through role playing and interventions to reduce expectations that smoking is normative behavior.

3. Long term prevention effects have been demonstrated to date only where peer leaders (either older "ideal" peer leaders or same age "actual" peer leaders) trained to assist in implementing the programs have delivered at least portions of the program. (It should be pointed out that this observation may prove to be culturally specific since a recent replication of the Minnesota program (Fisher et al., 1983) found a significant reduction of smoking onset at one year post test for a teacher-led program in Western Australia.)

4. Programs which emphasize the long term health consequences of smoking are generalling less effective than those which emphasize short term, especially social consequences, and teach social skills to resist pressures to smoke.

5. Program components which have been tested independently and for which no clear advantage has yet been demonstrated include: elicitations of public commitment not to smoke and the use of films or video tapes to provide role models and to stimulate classroom activities.

6. School-based prevention programs combined with television components appear to have great power for reaching whole families.

7. Social psychologically based prevention interventions found to be effective at grades six and seven have no measureable effect on cigarette smoking when implemented at grade ten, suggesting that (1) persons at the highest risk to onset (for whom early prevention interventions are effective) have already become smokers by tenth grade, and/or (2) smoking norms are such at tenth grade that social psychological interventions are not sufficiently strong to overcome them.

8. Best evidence to date does not support the efficacy of a packaged approach to smoking prevention. All effective programs have involved high levels of student participation in various forms which taken together may be considered under the rhuberic of behavior modification through social skills training.

9. Findings to date would support the value of multiple measurement techniques, including biological as well as self reports of cigarette smoking.

IMPLICATIONS OF SMOKING PREVENTION RESEARCH FOR ALCOHOL, MARIJUANA, AND OTHER DRUG ABUSE

There are several reasons to be optimistic that the proven approaches to smoking prevention can be useful for the prevention of other substance abuse as well. Associations among drug use of various types are well known. Among 10th grade San Fernando Valley students, we found that tobacco use correlated with alcohol use at r= .32 and .37 at the middle and end of 10th grade, respectively; and tobacco use correlated with marijuana use at r= .43 and .46. As a predictor of other drug use, cigarette smoking was just as reliable as marijuana use and more reliable than alcohol use. Another way to look at associated use among multiple drugs is to consider the likelihood that a person using one drug is also using another drug over the same period of time. The Los Angeles high school study (Johnson et al., 1982) found that 90.7% of cigarette smokers also drank, whereas only 18.1% of drinkers smoked cigarettes. Similarly, 74.7% of cigarette smokers also used marijuana, whereas only 29.1% of marijuana users smoked cigarettes. Although these findings say nothing about the order of progression in drug use, they clearly do indicate that cigarette smoking was a very good predictor of both drinking and alcohol use, predicting those behaviors better than it was predicted by those behaviors.

In order to test for order of progression we considered the use of each drug separately and in combination as a risk factor to the onset of use of the other two drugs over the 4.5 months of spring semester in 10th grade. Figure 6 reveals that onset of marijuana use over 4.5 months in tenth grade was 2.4 times as great among cigarette smokers than non-smokers, and 1.8 times as great among drinkers than non-drinkers. The risk to onset of marijuana use was almost four times as great among students who smoked and drank than among those who did neither. Both cigarette and alcohol use were independent risk factors for onset of marijuana use. Figure 7 reveals that cigarette smokers were also twice as likely as non-smokers to begin alcohol use. The relative risk for marijuana users was 1.9, and the relative risk of users of both alcohol and cigarettes was 2.6. Figure 8 reveals that marijuana use was also a risk factor for the onset of cigarette smoking, whereas alcohol use was not. Relative risk factors for marijuana use, alcohol use, and marijuana and alcohol use in combination were 2.8, 1.6 (not significant), and 3.0, respectively.

It is clear from these analyses that cigarette smoking, alcohol use, and marijuana use each can act as a gateway drug for onset of the others (with the possible exception that alcohol use may not increase the risk for onset of cigarette smoking). Consequently, it may be that successful prevention programs for cigarette smoking may act indirectly to reduce the onset of alcohol and marijuana use as well. The associations in patterns of drug use, and especially the importance of tobacco use as a risk factor for onset of other drug use suggest the possibility that preventing tobacco use may indirectly minimize risk to other drug use. At this point such indirect effects are only conjectural and need to be put to rigorous test.

SOCIAL PSYCHOLOGICAL PREVENTION PROGRAMS AND DRUG ABUSE ONSET

Two recent studies one of which has been reported (McAlister et al. 1981, Johnson et al.) and one which is yet to be reported, have begun to assess the potential for primary prevention of drug abuse. McAlister et. al. (1981) report that a peer-led, social skills training prevention program was successful in preventing onset of alcohol and marijuana use as well, even though the major focus of the curriculum was prevention of cigarette smoking.

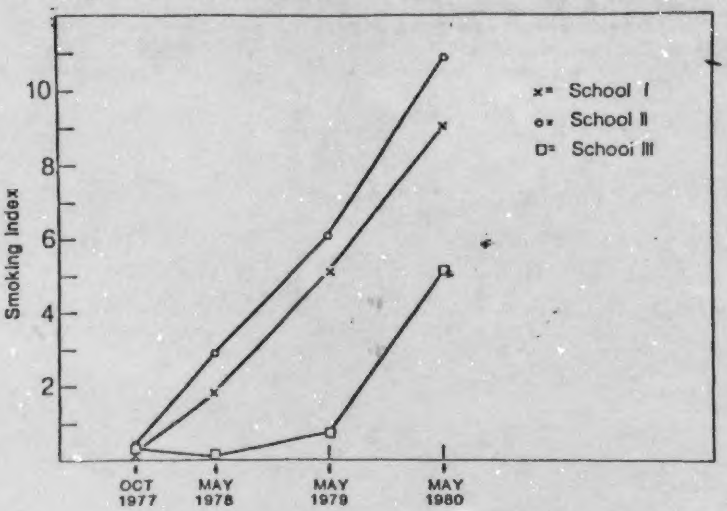
Johnson, Graham and Hansen (1982) found that the Los Angeles smoking prevention program for tenth grade students had an effect on marijuana smoking, even though the program contained no marijuana prevention component. The finding that marijuana use was affected, whereas alcohol use was not, consistent with a generalization gradient; marijuana unlike alcohol is generally ingested by smoking. One- and two-year year followups of the Los Angeles cohorts (in preparation) reveal a pattern that should be taken as a caution for implementing drug abuse prevention programs. At one- and two-year followups the least marijuana use onset was observed in peer-led, resistance skills training programs. However, the greatest onset was observed in teacher-led, resistance skills programs. Comparison conditions fell in between the two extremes. The finding that effects were strongest in the peer-led condition is consistent without experimental research in smoking prevention. However, this is the first time that we have found a backlash effect for a teacher-led program. This finding may be explainable in terms of psychological reactance theory. Until further research has clarified the mediating processes, caution should be exerted regarding programs implemented without peer leadership involvement.

Another study (Botvin, in preparation) reports that a social skills training drug abuse prevention program of 30 sessions at seventh grade was also effective in preventing marijuana and alcohol use. These researchers also have found positive prevention effects to occur only in the peer-led condition.

CONCLUSION

Consistent evidence from smoking prevention research, associations among different types of substance use, risk factor analyses for drug use onset, and now prevention research relevant to use onset for multiple substances suggest that peer-led social skills training programs applied in early adolescence can be effective in preventing the onset of drug abuse. Ongoing research will help clarify the conditions under which prevention strategies are most effective. Of great concern, however, are the significantly sizable populations of young people at high risk to drug abuse who are missed by school-based programs. Because of large rates of absenteeism and school withdrawals among young people at high risk, researchers should find ways to extend these promising prevention programs to other community settings in order to reach those at highest risk to drug use onset.

Figure 1 Smoking Index (Cigarettes/Student-Week)



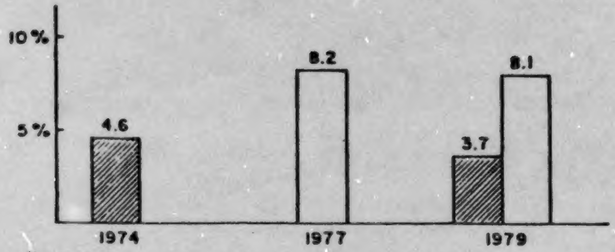


Figure 2 The Minnesota and the NIE Smoking Prevalence Data (Regular and occasional smoking) for 12-14-year-olds. Mean age for the Minnesota group was approximately 12 years; mean age for the NIE sample was approximately 13 years.

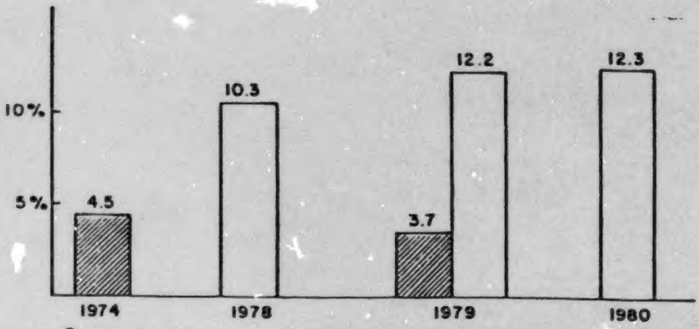


Figure 3 The NIE and Stanford Smoking Prevalence Data (Regular or weekly smoking) for 12-14-year-olds. Mean age for the NIE group was approximately 13 years; mean age for the Stanford group was just under 13 years. Measures were slightly different in the two studies.

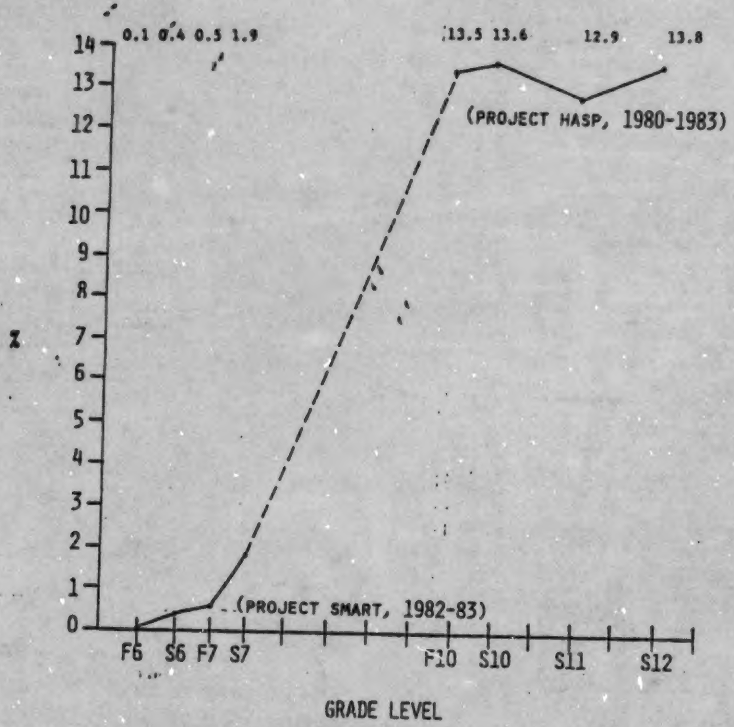


FIGURE 4: PROPORTION OF STUDENTS SMOKING ABOUT ONE OR MORE CIGARETTES PER DAY

FIGURE 5

PARENTS OF SMOKING HOMES REPORTING DIFFERENT LEVELS OF PROGRAM PARTICIPATION BY CONDITION

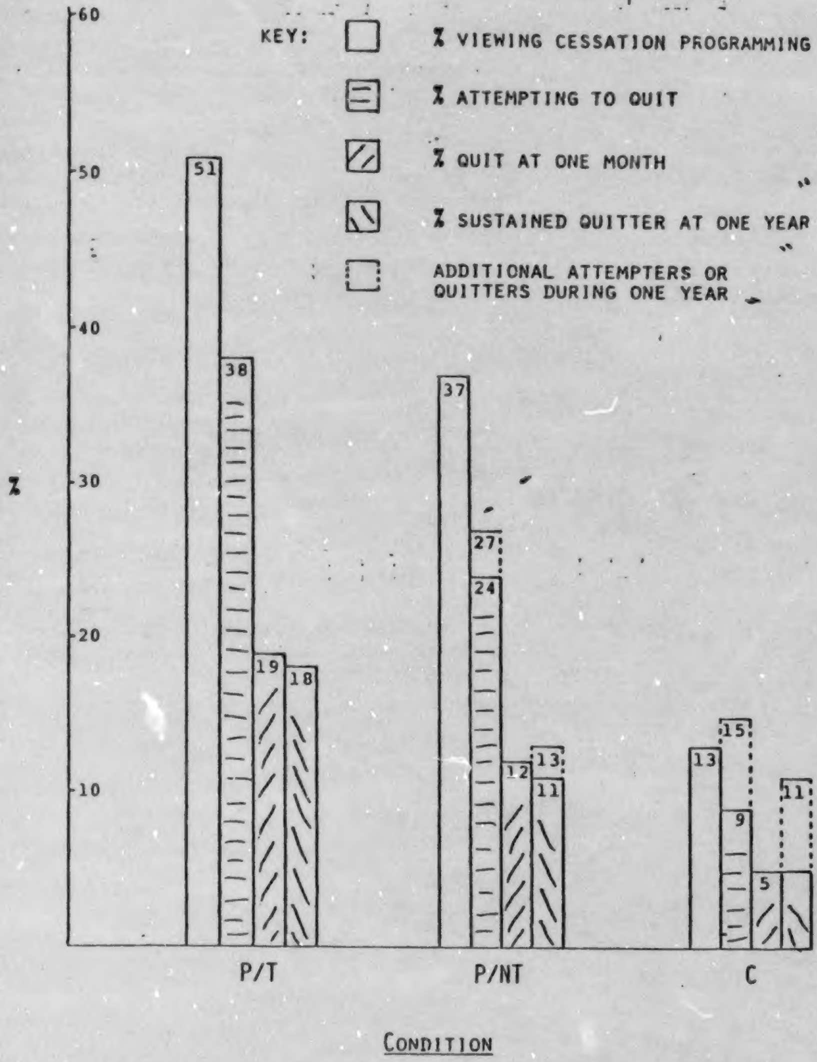


FIGURE 6.
MARIJUANA TRANSITIONS

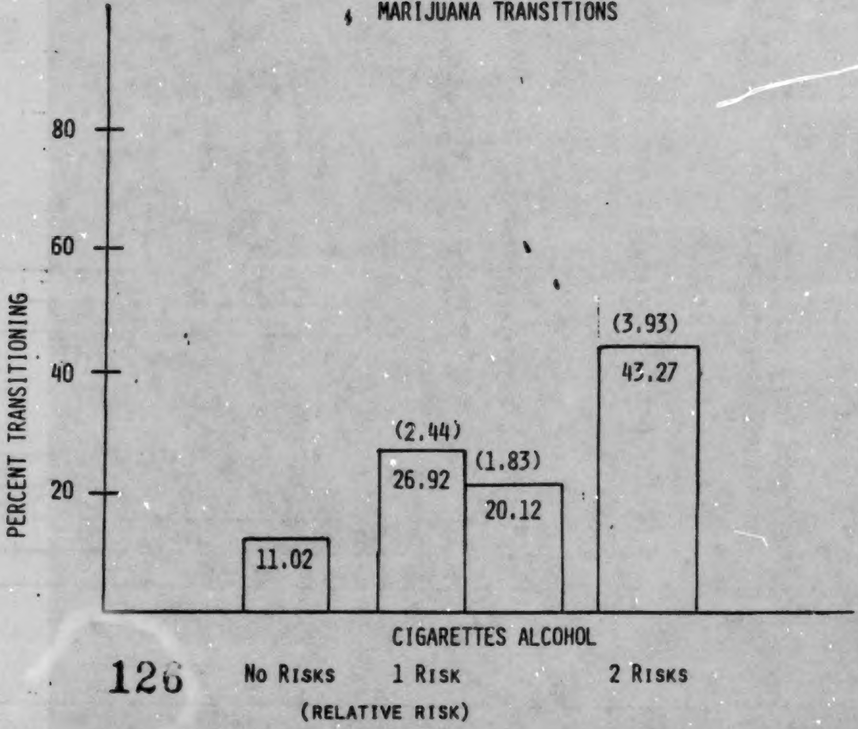


FIGURE 7

ALCOHOL TRANSITIONS

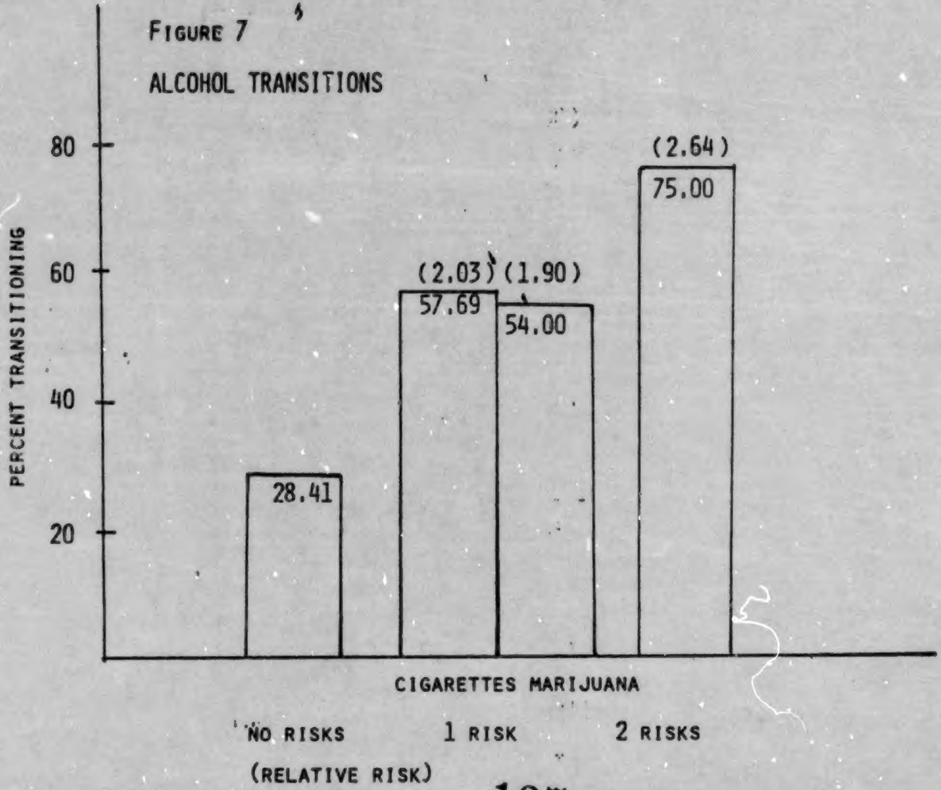
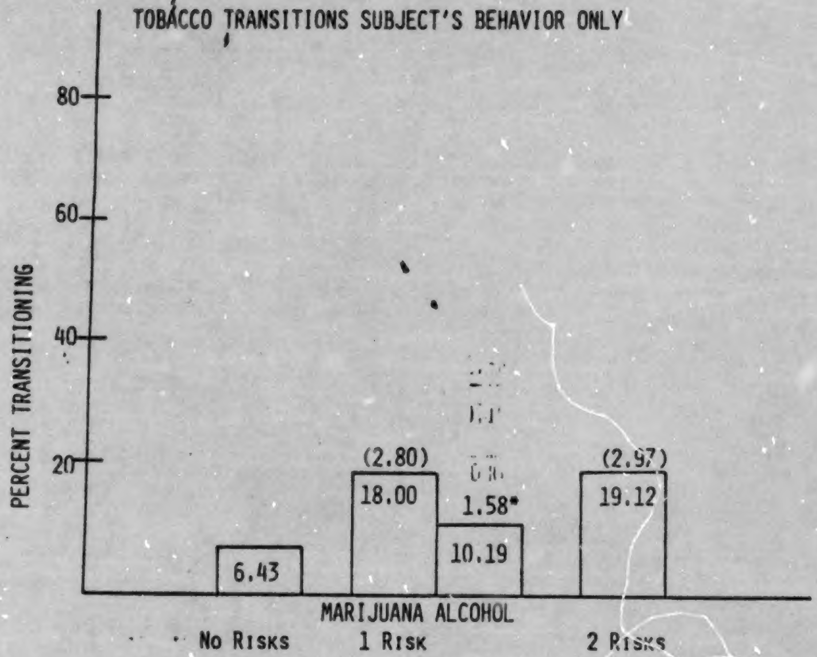


FIGURE 8.

TOBACCO TRANSITIONS SUBJECT'S BEHAVIOR ONLY



*N.S.

( )(RELATIVE RISK)

Mr. HUGHES. Thank you, Doctor.

Mrs. Rusche.

Mrs. RUSCHE. Thank you. I want to first of all thank you for the opportunity to appear before you today on behalf of the parents' movement and I want to thank you for mentioning the National Federation's conference next week. I would like to add that Mrs. Reagan is going to come and be our honorary chairman and we are so grateful to her for all that she has done to help call attention to this problem.

One of the things that Families in Action—my group back at home—does is collect information about drug abuse and all aspects of it as we have begun to redefine it. We now have over 100,000 documents in our drug information center and we publish "Drug Abuse Update," which you have a copy of in your notebooks.

If you would turn to page 11 of that, at the end of the prepared testimony I want to discuss with you a little bit more some of these statistics that NIDA's been collecting and interpreting. On page 11, you will see some charts that show different kinds of things. First of all, daily marijuana use among high school seniors at the top. Down on the right, you'll see a chart that shows regular or current marijuana use among high school seniors, and on the left you'll see current marijuana use among 12- to 17-year-olds.

Now, you'll also see that the dates vary some because these are two different surveys, but you'll see a heavy black line that shows the rise in regular and daily marijuana use among these age groups, and then you'll see the line become lighter in about 1978. We think that's significant for a number of reasons, which I want to get into with you.

First of all, as we look at these charts, it's very important to recognize that as recently as 20 years ago, in 1962, less than 2 percent of any 12- to 17-year-old child in our country had had any experience with any illicit drug. We go from there to 1978, if you'll look on the charts, and we see that almost 11 percent of our seniors were smoking every day, smoking pot every day, and we see almost 17 percent of our 12- through 17-year-olds in 1978 were using the drug regularly. We see 37 percent of our seniors are using it regularly. That's from less than 2 percent 20 years ago.

We also see that line turns lighter in 1978. That was the year that the parents' movement was really beginning to spread across the country. Some of the early parent groups began in late 1976 and 1977, but by 1978, the parents' movement was really beginning to spread. There were key groups in many States across the country.

Now, we take great encouragement from this downturn, but before we get all excited, will you turn the page of the publication you're looking at. When we put the three charts that were on page 11 in perspective and put them over a baseline of zero, we can still see how far we have to go to reduce daily use back to 1962 levels and reduce regular use among kids and among seniors to those same levels. So we're not by any means saying that the struggle is over.

We think we can take encouragement from these charts for a number of reasons, principally because parents have learned what we feel are some key tools that we hope you will focus on and that we hope we can persuade others to focus on. The first thing we've learned is that drug education does work. It just depends on what kind of education children receive.

Until the late 1970's, most of the drug education kids got, taught them how to become drug users. By 1978, for example, 11 States in this country had decriminalized marijuana and this got translated on the school yard as, "Pot is harmless," because, after all, legislatures wouldn't lift the ban on something that could hurt you, would they?

By 1978, some 30,000 head shops were doing business across the country. They were described by Dr. Mitchell Rosenthal, head of Phoenix House, as little learning centers for drug abusers. Head shops sold children things like imitation "Frisbee" pot pipes, practice grass kits for fifth graders with instructions on how to roll a joint and what to wear to your first practice grass party, comic books that taught children how to snort cocaine; "Coca-Cola," and "Campbell's Soup" stash cans, whose tops unscrewed and revealed inside chambers where you could hide drugs from parents and from police; candy-filled Christmas stockings with pot paraphernalia concealed inside and any number of other druggie toys and gadgets.

Movies, television, and music picked up where head shops left off, providing an endless litany of what parents call "do drugs" messages. These range, for example, from the movie "9 to 5," where three secretaries become friends—if you've seen that movie, you'll remember how did they become friends? It was over a joint that they smoked together after hours and where they got the joint was from Lily Tomlin's teen-aged son. That's a "use drugs" message.

"Use drugs" messages emanated from song lyrics that repeatedly hammer home the theme, "One toke over the line," "I get high with a little help from my friends," "Cocaine, cocaine, she's all right, she's okay," "I'm gonna' boogie all night 'cause I keep on tokin'." These are four refrains from four different popular songs. "To toke," verb, means to smoke marijuana; a "toke," noun, is a puff or a "hit" from a marijuana cigarette.

High Times magazine, available in bookstores, convenience stores, and other places that children frequent added yet another dimension to drug education with monthly market quotations of the going rate for all illicit drugs from nations around the world, and articles such as "How to Buy a Judge," "I Was JFK's Drug Dealer," and "Amputee Smuggling," which taught how amputees found extra hiding chambers for places to bring drugs in.

Sadly, the pot culture's "do drugs" messages were often reinforced throughout the 1970's by drug policymakers, both public and private, who counseled the Nation to accept the inevitable presence of illicit drugs in society and teach people how to use them responsibly.

The "responsible use" concept filtered straight down to the classroom. A high school text, for example, gives high school students "Hints for the Responsible Use of Marijuana." They include: Smoke with your friends; clean out the seeds; use a water pipe; and don't drop ashes or you'll burn holes in your clothes.

Parents redefined drug abuse as any use, any use of illicit drugs and said a resounding "no" to teaching the responsible use, a resounding "no" to head shops, and a resounding "no" to the decriminalization of marijuana or any other illicit drug.

Given what was happening to our generation of children, we insisted that marijuana be seen as a health problem, rather than only a legal one, and we insisted that teaching abstinence can change behavior, though the experts argued with us on that point.

We said back to them, "Look, we don't teach people how to smoke cigarettes responsibly; we teach people to quit because cigarettes are not good for their health." By redefining "drug abuse," parents began to establish clear signals to children and to others about what was and was not acceptable behavior. Society has begun to hear that message.

Since 1978, when that black line turns lighter on the charts, no State has decriminalized marijuana. Since 1978, some 35 States have passed laws to outlaw head shops. Since 1978, a growing number of children's role models, such as sports heros, movie stars and rock singers have begun to lend their voices to no drugs, rather than prodrugs messages.

Since 1978, hundreds of thousands of parents, educators, service organizations and government agencies have joined forces in educating people about the health hazards of drug abuse among children. We've also stopped calling it "drug use" and started calling it "drug abuse."

The second thing that parents learned is that drug education has to be followed with action. Telling children that drugs aren't good for them and they must stay away from them won't work if everyone else around them is saying quite the opposite. Parents have taken action to shut down head shops; they've worked for many kinds of antidrug legislation. They've also supported law enforcement efforts to begin enforcing existing laws.

For example, in our country, and in every State, selling alcohol to minors is against the law. The only thing is, we haven't been able to figure out what a "minor" is. In some States, he's 19, 18, 20, 21, et cetera. However, every kid can buy a six-pack, if he wants to, the minute he gets his driver's license and a little bit of money to go and purchase alcohol.

Parents are beginning to say, "These are laws on the books; let's get them enforced and let's do what it takes to get them enforced."

Parents also are going into the courts and monitoring lenient judges who tend to disregard the intent of the laws. An example of that is DUI, where judges will summarily dismiss DUI cases. In my county, we had 4,500 DUI cases go through our courts in 1 year. Often the most that happened to an offender on first, second, third, or even fourth offense, was a $250 fine.

Parents have gotten together with the parents of their children's peer group to establish guidelines they all feel comfortable with. Those are behavior guidelines and guidelines they can agree to enforce. Everything from when children need to be coming home on school nights; how long they should stay out on weekends; and promises not to serve alcohol to kids at parties; promises that chaperones will be there; and those chaperones will be adults.

Parents finally have modified their own use of society's legal drugs in order to begin providing children with appropriate role models and that includes prescription drugs, as well as alcohol and cigarettes.

The final thing that parents have learned, and I think is perhaps the most important lesson, is that they began to quit blaming themselves if their child became a drug user, and to refocus that blame where it's belonged all along: on the folks who are making money from what has now become a $90 billion illicit industry.

Once parents understood who was responsible, really responsible for the drug problem, they were able to start fighting back. Fighting back is what the parents' movement is really all about. It has brought about a change, albeit a beginning change, still a change in youngster's marijuana-using behavior, and it's brought about an astonishing change over 4 or 5 years in their attitude.

Since 1978, the number of seniors who think marijuana use entails great risk, as Dr. Pollin showed you this morning, has gone from 35 percent to 60 percent, but even more important is that the number of kids who fear their friends will disapprove of their behavior if they use drugs has gone from 34 percent to 75 percent. I think we need to pay attention to that.

Parents are showing that drug prevention works. They're the folks who are getting the job done and they're doing it on almost entirely a volunteer basis. We are fighting a $90 billion industry with nickles and dimes. But volunteerism is not free; it takes some basic operational support to generate the legions of volunteers necessary to do that work.

The Federal volunteer agency, ACTION, has understood this better than most, and to date is the only Federal agency, to my knowledge, that has begun to support direct operational expenses of key parent groups that are providing either local, State or national services. When I say "direct support," I mean giving the money to the parent groups who are organizing, not to any other intermediate agency, and putting the money in the pockets of those folks who are doing this work.

Traditionally, drug prevention has been the Cinderella of drug and alcohol services. About the only significant private philanthropical funds ever spent on drug abuse were used to create and fund the Drug Abuse Council. This is the Drug Abuse Council that was based here in Washington, which was a private drug abuse think tank that operated from 1972 to 1978.

An expenditure of $10 million of private funding over 6 years produced the following recommendations: A, that we focus national policy on teaching the responsible use of marijuana, cocaine and even heroin; that we legalize marijuana as soon as possible and that we decriminalize all other psychoactive drugs and that we consider as one of our policy options, over-the-counter heroin sales.

Until 1979, public funds through the Congress were allocated—I'm sorry, only 2 percent of public funds of NIDA's budget were allocated for drug prevention. In response to pleas from parents in the late 1970's, Congress increased NIDA's prevention allocation to roughly 10 percent, but that money was absorbed into the block grants.

In theory, returning moneys to the States for local control is a good idea, but in practice, the block grants are not working. The bottom line in my State is that drug and alcohol services must now compete for funding with other equally important services, such as maternal and infant care and mental retardation services. The result is ever-decreasing funds for an ever-increasing demand for services.

According to William Johnson, who is director of the alcohol and drug section of the Georgia Department of Human Resources, the most recent needs assessment in Georgia show that our State is now meeting only 14 percent of the need for treatment services in the drug and alcohol arena.

The consequences at the Federal level are the same. One unit of NIDA, for example, had a prevention budget of $16 million before the block grants. Its current budget is $500,000. The Institute has provided a great deal of technical assistance to the parents' movement from its inception, but most of that assistance has now disappeared because of the block grants and it was not replaced at the State level, where even basic treatment services have been cut so drastically.

I might add that the 20-percent allocation that is designated to go to prevention, when it gets back to the States, those 20-percent funds are going basically to the treatment centers, whose treatment funds have been cut so badly, in order to keep enough beds available, and the treatment people are going out and doing some awareness programs to justify receiving the 20 percent.

The parent's movement is extremely grateful to the Reagan administration for its commitment to increasing law enforcement efforts to stop drug supplies from entering the country, for we, too, believe that this is a double-barreled approach—that the double-barreled approach is what's going to work. You can't cut off one without endangering the other, and we've got to stop supply, but we've also got to stop demand.

Each of us has a very special place in our hearts for Mrs. Reagan, whose personal commitment to drug-free youth has been unparalleled. We recognize the pressures on the President and we recognize the pressures on you, the Congress, to provide more services with fewer dollars. But I hope that you will remember this third lesson that parents have learned, and that is, who is it that's responsible for this problem? We must really quit blaming ourselves, quit blaming various factions within the Government and various Government agencies at the Federal and the State level, and focus our anger on the people who are making all this money, this $90 billion, the illicit drug profiteers.

I think if we do that, we may begin to find some solutions to the dilemma. We realize that dollars are scarce and there aren't any extra ones to go around. But there are. If we begin to look at seizing the assets illegally obtained with drug money and liquidating those assets, we may generate a new source of revenue and then we may be able to spend it in a concerted effort on all the facets of this problem: Prevention, treatment, and law enforcement.

Thank you very much.

[The statement of Mrs. Rusche follows:]

Prepared Statement of Sue Rusche, Secretary, National Federation of Parents for Drug-Free Youth, Executive Director, Families in Action

I want to beginby thanking you for the opportunity to appear before you today in behalf of the parents' drug prevention movement. I represent two organizations in that movement.

One is the National Federation of Parents for Drug-Free Youth on whose Boare I serve. The Federation links together the 3,000 to 4,000 grass roots parents groups that have formed across the nation and helps new groups organize. It is based here in Washington where its Second Annual Conference will take place next week. I am delighted and grateful to be able to tell you that First Lady Nacy Reagan is Honorary Chairman of the Conference.

The second organization is Families in Action which we founded in 1977 in Atlanta and for which I serve as executive director. We maintain Drug Information Center which now contains over 100,000 documents filed under some 750 subject categories. Our Center serves as the information arm of the parents' movement. Appended to your copy of my testimony is *Drug Abuse Update*, a quarterly journal we publish in which we abstract information collected at the Center.

If you will turn to the charts on page 11, we can examine marijuana use among American children and adolescents over the past decade. This information is taken from 1982 surveys sponsored by the National Institute of Drug Abuse. The chart at the top shows daily marijuana use among high school seniors; at the lower right, regular use among seniors; at the left, regular use among 12 to 17-year-olds. It is important to recognize when we study these charts that just over twenty years ago less than 2 percent of American youngsters had had any experience with any illicit drug. By 1978, nearly 11 percent of high school seniors were smoking pot every day. Thirty-seven percent of seniors and 17 percent of 12 to 17-year-olds were using the drug regularly.

On all three charts the black line that traces the rise of marijuana abuse among youngsters turns red in 1978—the year the fledgling parents' movement began gaining momentum nationwide.

Now before you conclude the problem is over, please turn to the charts on page 12. When we place the charts in position over a base line of zero, we can see that our work is not over. We must double the reduction in seniors' daily use, triple the reduction in children's regular use and nearly quadruple the reduction in seniors' regular use before we even return to the usage levels of just twenty years ago.

Still, we can take encouragement from the initial turn-around of youngsters' marijuana involvement, for in bringing it about, parents hve learned much about how to prevent drug abuse.

The first thing we learned is that drug education works—it just depends on what kind children receive. Until the late 70's, most of the drug education kids got taught them how to become drug users. By 1978, for example, eleven states had decriminalized marijuana. This got translated in the school yard as "pot is harmless," because, after all, legislatures wouldn't lift the ban on something that could hurt you, would they?

By then some 30,000 head shops—described as little learning centers for drug abusers by Phoenix House President Mitchell Rosenthal—were flourishing in neighborhood stores and shopping centers. There children could buy imitation "Frisbee" pot pipes; practice grass kits with instructions on how to roll a joint and what to wear to one's first practice grass party; comic books teaching how to snort cocaine; "Coca Cola" and "Campbell Soup" stash cans designed so drugs could be hidden from parents and police; candy-filled Christmas stockings with pot paraphernalia concealed inside; and any number of other druggie toys and gadgets.

Movies, television and music picked up where head shops left off, providing an endless litany of what parents call "do drugs" messages. Thses ranged from "Nine to Five" where three secretaries become friends over a joint one procures from her teenage son to song lyrics that repeatedly hammer home the theme: "One toke over the line; I get high with a little help from my friends; Cocaine, cocaine, she's all right, she's okay; I'm gonna' boogie all night cause I keep on tokin'. (To toke, v., is to smoke marijuana; a toke, n., is a puff or "hit" of a marijuana cigarette.)

And High Times Magazine, available in book and convenience stores that children frequent, added yet another dimension to drug education with monthly market quotations of the going rate for all illicit drugs from nations around the world and articles such as "How to Buy A Judge," "I Was JKF's Dealer," and "Amputee Smuggling."

Sadly, the pop culture's "do drugs" messages were often reinforced throughout the seventies by drug policy makers who counseled the nation to accept the "inevitable" presence of illicit drugs in society and teach people how to use them "responsibly." The "responsible use" concept filtered straight down to the classroom. A high school text book, for example, gives students "Hints for the Responsible Use of Marijuana:" smoke with friends, clean out the seeds, use a water pipe, and don't drop ashes or you'll burn holes in your clothes.

Parents redefined drug abuse as *any* use of illegal drugs and said a resounding "no" to "responsible use," head shops, and decriminalization. Given what was happening to our whole generation of children, we insisted that marijuana be seen as a health problem as well as a legal one and we insisted that teaching abstinence can change behavior. After all, we don't teach people to smoke cigarettes responsibly, we teach them to quit because tobacco is not good for their health. By redefining drug abuse, parents began to establish clear signals to children about what was—and was not—acceptable behavior. And society has begun to hear parents' message.

Since 1978, no state has decriminalized marijuana. Since 1978, most states have outlawed head shops. Since 1978, a growing number of children's role models—sports heroes, movie stars, rock singers—have lent their voices to no-drugs, rather than pro-drugs messages. And since 1978 hundreds of thousands of parents, educators, service organizations and government agencies have educated people about the health hazards of drug abuse among younsters.

The second thing parents learned is that drug education must be followed up with action. Telling kids to stay away from drugs won't work if everyone around them is saying the opposite. Parents have shut down head shops and worked for other anti-drug legislation. They've supported law enforcement efforts to enforce existing laws. They've monitored courts for lenient judges who disregard even the intent of the law. They've pressured concert hall owners to enforce ordinances against selling alcohol to minors at concerts. They've gotten together with the parents of their child's peer group to establish teen guidelines they all feel comfortable with—and agree to enforce. They've modified their own use of society's legal drugs in order to provide children with appropriate role models.

The third thing parents learned was to quit blaming themselves if their child became a drug user and to re-focus that blame where it had belonged all along—on the folks making money from what has now become a $90 billion illicit industry. Once they understood who was responsible for the drug problem they were able to start fighting back.

And fighting back is what the parents' movement is really all about. It has brought about a change in youngsters' drug-using behavior and an astonishing change in their attitude. Since 1978, the number of high school seniors who think marijuana use entails great risk has risen from 35 to 60 percent, while the number who fear their friends would disapprove of such behavior rose from 34 to 75 percent.

Parents are showing that drug prevention works. They are the folks getting the job done. And they are doing it on an almost entirely volunteer basis, fighting a $90 billion industry with nickles and dimes. But volunteerism is not free. It takes some basic operational support to generate the legions of volunteers necessary to do the work. The federal volunteer agency ACTION has understood this better than most and is the only federal agency that has begun to support direct operational expenses of key parent parent groups that are providing either local, state or national srvices.

Traditionally, drug prevention has been the cinderella of drug and alcohol service. About the only significant private philanthropical funds ever spent on drug abuse were used to create and fund the Drug Abuse Council, a private drug abuse think tank that operated from An expenditure of $10 million over Six year 1972 to 1978./ Produced recommendations that we focus national policy on teaching responsible use, legalizing mariguana and decriminalizing other psychoactive drugs, including over-the-counter heroin.

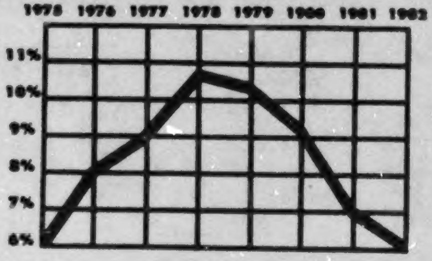
Until 1979, Congress allocated only two percent of the budget of the National Institute on Drug abuse to drug prevention. In response to pleas from parents, Congress increased the prevention share to roughly 10 percent, but the money was absorbed into block grants. In theory, returning maneys to the states for local control is a good idea but in practice block grants are not working. The bottom line in my state is that drug and alcohol services must now compete for funding with other equally important services such as materal and infant care and mental retardation services. The result is everdecreasing funds for an ever-increasing demand for services. According to William Johnson, director of the Alcohol and Drug Section, Georgia Department of Human Services, current needs assessments show that our state is meeting only 114 percent of the need for drug and alcohol services.

The consequences at the federal level are the same. One unit of the National Institute on Drug Abuse, for example, has a prevention budget of $16,000,000 before block grants; it's current budget is $500,000. The Institute has provided technical assistance to the parents' movement from its inception. Most of that assistance vanished with block grants, and was not replaced at the state level where even basic treatment services have been cut so drastically.

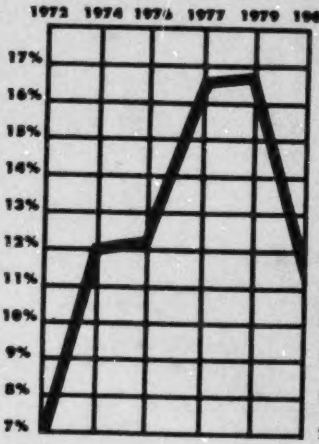
The parents' movement is extremely grateful to the Reagan Administration for its commitment to increasing law enforcement efforts to stop drug supolies from entering the country. And each of us has a special place in our hearts for Mrs. Reagan whose personal committment to drug-free youth is unparalleled. We recognize the pressures on the President and on Congress to provide more services with fewer dollars. But remember that third lesson parents have learned. If we quit blaming ourselves for the problem and re-focus that blame on illicit drug profiteers, we may find solutions to the problem. By seizing assets illegally obtained and liquidating those assets, we can generate funds for prevention efforts to reduce demand, law enforcement efforts to reduce supply, and treatment services for the drug industry's victims.

PREVENTION WORKS . . .

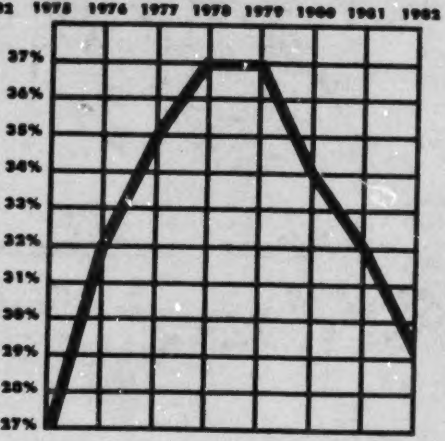
DAILY MARIJUANA USE:
HIGH SCHOOL SENIORS



CURRENT
MARIJUANA USE:
12-TO 17-YEARS-OLDS



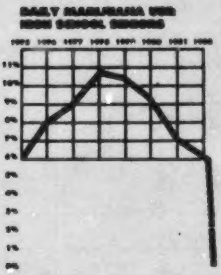
CURRENT MARIJUANA USE:
HIGH SCHOOL SENIORS

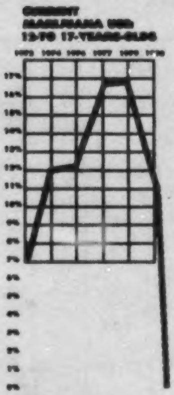


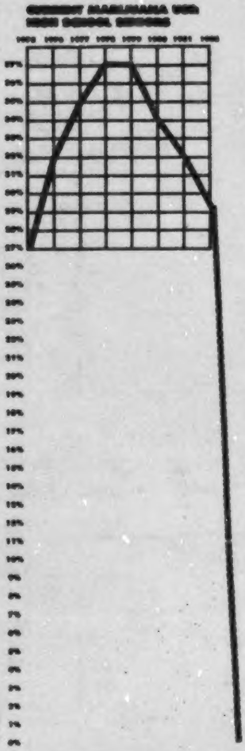
▬ Before Parents' Drug Prevention Movement Began
▬ After Parents' Drug Prevention Movement Began

Daily use is use 20 or more times in the month before the survey. Current use is use at least once in the month before the survey.

. . . BUT WE'VE GOT A LONG WAY TO GO!







DRUG FREE YOUTH THRU DRUG EDUCATION

FAMILIES IN ACTION

SUITE 300 [illegible] NORTH DRUID HILLS ROAD DECATUR GA [illegible] TELEPHONE [illegible]

NONPROFIT ORG.
U.S. POSTAGE
PAID
ATLANTA, GA
PERMIT NO. 2894

Mr. HUGHES. Thank you, Mrs. Rusche.

Dr. Riddile.

Dr. RIDDILE. Yes. I, too, would like to express my appreciation for this opportunity to address this committee. I've had the unique opportunity and experience —in just about every facet of the drug prevention and now treatment field, except for medical research on drugs and I think we're going to spend a lot of money on research about drugs—why people use drugs, and I think we're going to find out that people use drugs because they make them feel good.

—I want to address some issues before I address what I think is part of a comprehensive plan and I think that's the one word I would like to emphasize, "comprehensive," because I think we cannot emphasize one aspect of prevention over another.

First is social tolerance and I think Sue Rusche has just given an example, one segment of our society. Some parents who became informed about drug abuse, what it was doing to young people, and their tolerance levels diminished considerably and they took action. I think that's one—the figures that she's given is an indication of what can be done.

I think we need to do a lot more. I think the tolerance level in our whole society for drug use is much too high. I think that statements from parents or adults, like, "Well, kids use marijuana and cocaine today; that's a part of growing up, and what I did was drink beer." I think that reflects an alarming lack of awareness about what drugs are doing to young people in this country today.

Availability is a key factor in use. I think efforts to eradicate drugs at the source should be continued, but not looked upon as the answer.

The other issue is abstinence versus responsible use. My belief is there's no such thing as "responsible use" of illegal drugs. There's no such thing as "responsible use" of drugs by growing, developing kids, 12-, 13-, 14-year-old young people. I don't think any drug use can be responsible; it's all abuse.

What we're talking about is abstinence. I think our goal must be abstinence. I think our goal must be to delay at least the use of legal chemicals like alcohol as long as possible, because the earlier the person is introduced to a drug, the higher the probability they will have of having a dependency problem with that particular drug.

In terms of prevention, we need to look at a comprehensive overall prevention program. Prevention really has three levels. First, primary prevention, keeping people from ever using a drug. Obviously, that is the most desirable. If we can prevent people from ever using it, they're not going to have a problem with it.

The second level is early intervention, secondary prevention. That is, stopping use at an early enough stage where the likelihood of being successful in treatment or in stopping use is high.

The last and final level is treatment, intervening with the person whose lifestyle or life has been adversely affected by the use of drugs.

First, primary prevention. I think having written the curriculum in the school, having taught drug education, having counseled kids in schools, having been an administrator in schools, having developed counseling programs for kids in schools, it's clear that drug education must start when kids enter school.

There are two components: An affective component or attitudinal component, and that's working on attitudes and values; and an informational component, giving people information about drugs and the harmful effects, the adverse effects that drugs have on their health.

Now, the attitudinal components should be emphasized earlier. The younger the child, the more we should work on attitudes for two reasons: One, we want to develop attitudes and values about drug use prior to their introduction; and two, to give them some time to process that information, to let those attitudes sink in so that the likelihood of abstinence is higher so that they'll emotionally accept the information that they've heard.

Drug education should start early, very early and particularly emphasize handling peer pressure, how to say "No." Efforts to curb cigarette smoking should start in the fifth and sixth grades; alcohol, sixth grade; marijuana, as early as sixth grade because we're finding that kids are using drugs at earlier and earlier ages.

Mr. HUGHES. I wonder if I can just interrupt you there. I apologize, but we have a vote. We have about 7 minutes for us to get to the floor, so we're going to take a very short recess and we'll be back to complete the testimony.

The subcommittee stands in recess.

[Recess.]

Mr. HUGHES. The subcommittee will come to order.

Again, I apologize for the interruption. Doctor, why don't you just go ahead and proceed.

Mr. RIDDILE. OK, let me just begin with just briefly go over what I think is needed in a prevention effort, a primary prevention effort. That is, again, drug education should begin when children enter school; it should include an attitudinal component, an affective component; and an information component.

I think we spend too much times sometimes on information, particularly for older kids. As Dr. Johnson mentioned, it's not very effective to do cigarette prevention with older kids.

I think what we need to do with junior high and high school youngsters is to let them know what dependency is; why people use drugs; motives; what dependency is so they can recognize the signs, at least if not in themselves, in their friends and people that they're close to, and let them know where they can get help. In other words, an early intervention program.

I think it's very difficulty to do any kind of prevention after something's already occurred. We're finding kids at younger and younger ages, by ages 12 and 13, introduced to pot, alcohol. It's very difficult to prevent use after it's already started. It's too late.

In terms of treatment, I think what's needed is not throwing a lot of money at treatment; rather, in terms of the whole prevention effort, is encouraging local initiative. I'll just tell you what happened in the community that I live in.

I was working with the school system and working with parents in a parent education movement, much as Sue described. The parents were educating themselves about drug use, drug abuse, and forming parent groups. What came out of that was a new school curriculum, 15 laws passed in 1 year in the State legislature in Virginia, a new treatment program in the community because people were being identified who had drug problems, because parents were alerted, they were educated, they knew what the signs of dependency were and they knew where to go for help.

That action on their part, that taking of the initiative was what really started that community on a comprehensive program. Because all levels are needed at primary prevention. And certainly I agree with Dr. Johnson—and we were talking during the break—that making an issue of cigarette smoking is what I think is important about his program, because in the 1970's, what we did was we said, "OK, they're going to smoke a few cigarettes, at least they're not doing drugs."

"They'll drink a little alcohol; at least they're not doing drugs." And "They'll try pot; I know they'll probably try pot." That's a reflection of the tone I was speaking about. But what this program does is it draws the line at cigarettes. It makes an issue of cigarettes. It says, "Cigarettes are harmful; they are a drug."

Compared to cigarettes, then, marijuana smoking looks like a mountain compared to a molehill. It relates to those young people the real importance of the issue to health.

But a comprehensive program begins when children enter school and it recognizes that primary prevention isn't always effective. We know that by providing information, we can change attitudes, but we can't guarantee that changes behavior. One aspect enters into the picture that we can't control, and that's peer pressure. As long as the attitude exists among young people in this country that a normal part of growing up in our society is trying pot and drinking, then we're really fighting a very difficult battle.

That's what we have to change; we have to change that attitude and that does take time. The problem with prevention efforts is finding enough resources to follow those people long enough to say, "This is how it works because I know 10 years down the road, these same people—this is the success rate we have."

We need to let the parents encourage and provide incentives for parents to take action in the community; to provide assistance, technical assistance, as it is called, for parents to take action, because I think that in the hands of the parents of this country rests the ability to do something about the drug problem.

If I were going to count on something happening; if I were going to take one area of primary prevention, parent action and treatment, I would put my money with the parents. I would encourage the parents. I'm not saying the Government take over the parent movement; provide the parents with direct assistance, because what we found is that when the bureaucracy attempts to take over parent initiative it disappears. It diminishes. So we must find a way to provide them with the needed resources, but not take over for the parents.

One of the aspects I think that has came up, is that of physical dependence versus psychological dependence. The issue of cocaine came up as an example.

If a drug is destroying a person's life, does it make any difference if it's physically or psychologically addictive? Cocaine certainly has been proven to destroy animals in laboratories. Marijuana certainly, by testimony, can destroy families, destroy young people. Alcohol is responsible for the slaughter of thousands of kids on the highways every year.

Do we need to know that answer? How important is that answer? I guess I'd just like to repeat my statement before that I think, at least from my own experience, that involving the community, allowing and encouraging local communities to take the initiative, I think, you'll see comprehensive programs develop.

I think we need to find ways to support local communities. I don't think just pumping money into this problem is going to resolve it because it takes more commitment, the commitment of families, the commitment of professionals, the commitment of concerned citizens. This problem takes a high level of commitment and won't be eliminated or even reduced to anything close to an acceptable level unless we encourage that local and personal initiative on the part of the community.

Thank you.

[The statement of Mr. Riddile follows:]

STATEMENT BY MEL J. RIDDILE, ED.D., BEFORE THE U.S. HOUSE OF REPRESENTATIVES, SUBCOMMITTEE ON CRIME, SEPTEMBER 22, 1983

Mr. Chairman, members of the Committee. I would like to express my appreciation to you for affording me the opportunity to address this Committee on the drug abuse issue which threatens to erode the fabric of our society. I have had the unique opportunity of working in virtually every aspect of the drug abuse prevention field. I have taught drug education in the classroom, organized counseling programs in schools, written curricula, trained professionals, organized parent education and support groups, and most recently, directed a treatment program for chemically dependent youth.

The issue before this Committee today is what do we do about the problem, how can this nation mount a formidable response to drug abuse; a response that is both efficient and cost effective? I will direct my remarks toward the prevention of drug use, which consists of three levels; primary prevention, stopping use before it begins, secondary prevention or early intervention, and tertiary prevention or treatment.

Prior to even looking at the topic of prevention, several issues must be addressed. The first being that of supply and demand. Efforts must increase to eradicate drugs like marijuana and cocaine, both domestic and foreign, at the source for two reasons. First, simple economic principles indicate that when the supply is decreased, the cost of the drug will increase. Thus, the drug will be more expensive and less available to certain segments of the population, particularly the adolescents who are less able to afford the drug. Secondly, availability of drugs is a major factor in predicting dependency problems among certain social groups.

In this light, we must give serious consideration to limiting the availability of alcoholic beverages to youth. When minimum drinking age was lowered to eighteen, the effect was to make alcohol readily available to fifteen, sixteen, and seventeen year olds. Lowering the drinking age created nightmares for police, school officials, and parents and has contributed greatly to the wholesale slaughter of our youth on America's highways.

However, merely limiting the supply will not necessarily reduce the demand for mood altering chemcials. This is why a prevention program is so essential. Unless we can do something to change the belief, that in order for one to feel good or avoid feeling bad, one needs a chemical, then we will be fighting a losing battle.

Over the past decade, this country has developed a tolerance for drug use that sees us accepting levels of illicit drug use among the adolescent and young adult population which twenty years ago would have seemed impossible to imagine. Attitudes expressed by adults like "smoking marijuana and snorting cocaine is what kids do today; when I was growing up it was drinking beer", reflects a frightening lack of awareness of the scope of the problem and the damage drug use does to young people, schools, families, and communities. I wonder when our tolerance will peak and when Americans will say, "We've had enough!" Remember, the only segment of our society whose life expectancy is declining is the 15-24 age group—the heaviest group of drug users in our society.

What is our goal? Is it responsible use? How can one responsibly use illegal drugs? Is our goal abstinence? Is it possible to think that we can stop everyone from using marijuana or cocaine. For certain groups in our society, the answer is yes. If we hope to see this generation of young people develop into mature, productive citizens, the leaders of tomorrow, our response must be yes.

Abstinence can be our only response. No drug use by growing, developing young people is acceptable. How many beers can adolescents drink before driving when we know that just one beer means that they are much more likely to have a traffic accident that an adult who drinks just one beer. How many joints of marijuana is it okay to smoke before going to school or how many snorts of cocaine is it okay to take before going on a date? The answer can only be, no drug use by young people is acceptable.

Thus, this nation is faced with the challenge of launching a massive public education effort to deal with a drug problem that threatens the growth and development of our youth, the stability of our family, the productivity of our industry, and the defense readiness of our military. Whether we are aware of it or not, we are all affected by drug use.

PREVENTION

A comprehensive prevention program should be multifaceted and directed toward all groups. The difficulty in developing and implementing such a program results from the fact that there is no one answer or solution. Programs must be developed to meet the needs of young people at various ages and stages of development, parents, and professionals including health care providers, educators and recreation specialists.

PRIMARY

The ideal situation would be to prevent people from ever using mood altering chemicals. A more realistic goal may be to delay use as long as possible. One factor that has contributed significantly to drug probems among our youth has been the declining age at the time of first use. Younger persons have less coping mechanisms and therefore higher probability that they will develop a problem related to the use of mood altering chemicals. This fact again points to the need to take a long look at the need to raise the drinking age.

Prevention should begin when the child enters school. It should include an affective or attitudinal component and a cognitive or informational/decision-making component. The younger the child, the more time should be devoted to the attitudinal component for two reasons. First, the need to establish a value system prior to that age when children become increasingly susceptible to peer pressure and less under the control of their parents. And secondly, to allow ample time for an intellectual understanding of the facts surrounding drug use to grow into an emotional acceptance prior to that time (junior high) when exposure to drugs increases dramatically.

Too much time in drug education programs is devoted to providing "drug specific" information. That is, details about the various harmful affects of different drugs. The problems is not the drug, but how people use the drug and the effect the drug has on peoples' lives. Alcohol, marijuana, and cocaine have existed for hundreds of years. Why are we now having such a problem in our society? There are a myriad of reasons provided including increased wealth and leisure time, increasing tension and stress of modern life, decline of the family, and increased availability of drugs, all of which may be true.

Unless we help people look at and deal with the motives underlying the use of mood altering chemicals and the serious effects of drug use on peoples' lives, we will find ourselves educating the public about the dangers on an endless number of new and "better" drugs. Therefore, I believe that our educational efforts should increasingly deal with providing people with the means to recognize chemical dependency in themselves and others and how and where to seek help.

Most prevention efforts are based upon the premise that information leads to attitudinal change which leas to behavioral change. That is, providing information about drugs will at some point change attitudes which will result in a decision to abstain. This theory seems plausible. Information may help some young people to resist, at least initially, the lure of a chemical which provides a quick, reliable way to change feelings, at a time when learning to deal with feelings is so critical to development.

One variable which they theory does not take into account is peer pressure. Peer pressure is so powerful that it can override information and short circuit all the drug education and parental guidance previously provided. Peer pressure and the widespread attitude among young people that using mood altering chemicals is a "normal" part of growing up in America, gets kids to take that initial first step, which runs in opposition to all that they have been taught by teachers and parents. It is true, most kids turn down drugs the first few times they are offered. But as long as the majority of young people used mood altering chemicals or passively accept drug use, common sense tells us that it will be difficult for any child to resist. Drug use is a normative behavior among our youth and we must recognize that fact.

While educating young people about drugs and drug-use is important, I believe more can be gained in a shorter period of time by educating adults, parents and professionals. Adult ignorance, next to peer pressure and availability, is a major contributor to drug-use among our youth. Well informed parents who involve themselves in community prevention efforts, and who communicate their values and beliefs about drug-use to their children in an open way are our best hope of preventing drug-use. Efforts to educate parents, such as those currently being conducted by the National Federation of Parents for Drug-free Youth and PRIDE must be encouraged, supported, and increased.

INTERVENTION

Chemically dependent people do not have to "hit bottom" before help is provided. In fact, the earlier treatment is provided, the higher the chance for success. Tried and tested methods and procedures are available to encourage dependent individuals to seek treatment. But in many cases, families and loved ones who are experiencing the pain of living with a chemically dependent person not only do not know that these services are available but in fact, some may not even be aware of the real source of their problems.

Therefore, two tasks must be accomplished before intervention can be accomplished. First, the public must be educated as to the behavioral signs of chemical dependency. Secondly, the public must be informed that there is hope, that help is available to them.

TREATMENT

The issue in regard to treatment is not that there is or is not enough available, although there is a shortage for young people, but how do we get the people into treatment that need to be there. Too often we are forced to wait until individuals break enough laws and are involved in the judicial system long enough so that they are sentenced into treatment.

I am reminded of my involvement in a situation in which I, as a school official attempting to deal with a disruptive student, had no alternative available to me but to seek a temporary exclusion of the student from school. Six months later, as I was visiting a local treatment facility, I encountered the young man, then a client. I quickly learned that, in order for him to receive treatment, he had broken into thirty homes in the area. This is both unnecessary and inexcusable.

Chemical dependency is both a contagious disease, passed from one person to the next, and multigenerational disease, passed from one generation to the next. It is the only recognized disease that I know of in which the person with the disease is asked "Would you like treatment, and how and where would you like to be treated?" It is ironic that, other than individuals with severe mental disorders, chemically dependent persons are, because of the dilusionary effects of the chemicals on their minds, the least able to make a decision that is in their best interest. We must have legislation that will assist parents and loved ones in helping these individuals obtain needed treatment. If we had cancer clinics that were as effective in treating cancer as we have effective chemical dependency treatment facilities, it would be impossible to build new ones fast enough. Yet, drug-use is the major cause of death for adolescent and young adults in this country today. How many must die, how many lives and homes must be ruined before we open our eyes? I contend that if the public was made aware of the facts and how they and those around them are effected by drug-use, the demand for more treatment facilities would increase. A community which educates itself about drug-use and the signs of dependency will find that the new awareness will not only increase primary prevention programs but will begin to surface individuals in need of treatment. The community will then see the need for treatment and take steps toward obtaining a treatment facility in their community. This is exactly what happened in the Washington Metropolitan Area where the awareness efforts have resulted in the opening of the Straight program and a number of other treatment programs. Public awareness is the key to the entire prevention efforts. An aware, educated public will work to develop effective prevention programs, they will form educational and support groups to inform parents, and they will raise money and contribute volunteer time to help treatment programs operate.

Merely throwing money at the drug problem will accomplish little. By utilizing local resources and by providing those resources with the skills and tools to organize a community campaign, those communities will develop a commitment and take the initiative to see that their community does something about its drug problem.

I am proud to say that I have been part of such a community effort and I can say that the power to resolve our nations' drug problems rests in the hands of the parents and concerned adults and professionals in cities and towns throughout this country. They need and deserve our support.

Mr. HUGHES. Thank you very much, Doctor.

Let me just ask a couple of questions because I think your testimony is very self-explanatory and you've done a good job of laying it out for us. I was curious about something that one of the speakers of the previous panel suggested about the interjection of youngsters into, for instance, a school system to share their own experience on what it's done to their life, and try to relate.

One of the suggestions that was made was that some studies a few years ago suggested that you're raising the question of drugs and that has a negative component to it. For that reason, that may not be a very good idea.

What do you have to say about that?

Mr. RIDDLE. OK, I think it's very clear that is effective if it's part of a comprehensive program. When you do one-shot deals, assemblies, it actually encourages experimentation because they see a former dependent person and say, "Well, look, he's done all these drugs; he's had all these problems and look where he is today. He's out in front of an audience again."

OK, the second thing is the way they do it. Many times, I've seen people build their egos from where they've been and how bad off they were. So it's the way it's done also.

We encourage that as a part of a comprehensive program. For instance, a 6-week unit on alcohol would include 1 day when recovering teenage alcoholics would come in and talk to the class, to individual classes, small groups, not in large groups. But it has to be done as a part of a program.

People are looking for a quick solution to this problem. There isn't, so it has to be part of a program.

Mr. HUGHES. It makes sense to me.

Mrs. RUSCHE. I'd like to add some things to that. I think you and I respond to these two youngsters because they look like our kids. I think black parents would have a very difficult time relating to what they said, but if some black kids came to some black parents, they could relate more clearly, or to some other black kids.

I think that what happened—I know there is controversy about this, but I agree with you that when you have someone who's gone through the experience sharing that story, if that person is like the person he or she is speaking, they'll relate to each other.

The second thing that I think is important and is lost sight of is that it was that very theory that persuaded the Department of Education in the early 1970's to put a moratorium on any drug education programs in the schools. So a vacuum was created and what filled that vacuum was many more prodrug messages than "don't use drugs" messages.

Mr. **Hughes**. If I understand what was said repeatedly throughout your testimony and other testimony, that we have to do as much of a job in educating parents as we do youngsters. Is that one of the——

Mrs. **Rusche**. I'd like to add to that if I may for a moment. I think parents in the broader sense of the word—some of the questions that we heard here today surprised us because we're jaded and we've grown used to some of those questions, but I'd like to come and do a drug awareness program for the U.S. Congress. Then I'd like to do one for the judges in my county.

Let me give you an example. One of the teenagers in our area a few years ago—he had some "Rush" at school. The school principal caught him and called the police. The police pressed charges against him and he went before the juvenile court judge. The juvenile court judge said, "Come on, you knew this was illegal; you shouldn't have had it in your possession, right?" And the kid said, "No, I really didn't." The judge said, "Well, where did you get it?" and he said, "From a head shop." The judge said, "What's a head shop?"

I mean, you know, it's a wonderful cycle, but we all need to become more aware of what our children know about than any—they're more knowledgeable than all the rest of us and we need to find out, all of us.

Mr. **Riddile**. We have professionals visit our program twice a week, psychiatrists, people from every walk of life, and they ask the same questions. It's almost like—I describe to the young people when they were finished with their testimony today that they had visited Mars and nobody had visited Mars. Everybody was trying to find out what it was like on Mars.

Basically—I'm not criticizing adults, but it's true. Kids are growing up in a different environment because drugs have entered into the environment. We all felt peer pressure as youngsters, as adolescents, but I never felt pressure to use drugs. It's a totally different environment, even maybe than it was 15 years ago, because now the pressure is, if you don't do drugs, then you're different. Then you're the odd ball; you're the person left out, and there's something wrong with you because you don't do drugs.

I saw that change. Within a period of time maybe 1975 to 1978, I saw that whole thing turn around, where a small minority of kids were doing drugs and were ostracized by their peers to where a majority of the kids were doing it and it was accepted or passively defended. In other words, they passively accepted or defended a person's right to do drugs because they're not bothering anybody else.

I think we need to educate. Certainly peer pressure, availability of drugs and adult lack of information are three factors that I cite as being prime contributors to the whole problem because think about it. Drugs are the first thing that kids know more about than their parents. They don't have to go to their parents anymore to ask them, "What about this?"

The kids are the experts. Sixth grade teachers are horrified to teach—or they're afraid to teach drug education because the kids know more than they do.

Mrs. **Rusche**. Unless they're using drugs, which is sometimes the case.

Mr. HUGHES. Sometimes a problem, I know.

The gentleman from Michigan.

Mr. SAWYER. Yes; I just have a question about these charts on page 11 of the report.

Mrs. RUSCHE. Yes.

Mr. SAWYER. The top one, for example, only shows a drop of about 4½ percentage points over the 4-year period, right?

Mrs. RUSCHE. That's the problem of the size that we made that line. The drop is from almost 11 percent; it's 10.7 percent to 6 percent.

Mr. SAWYER. Well, that's a drop of about roughly 4½ percentage points.

Mrs. RUSCHE. Oh, that's right, yes. I'm sorry, you're right.

Mr. SAWYER. The others, the one on the left bottom represents a drop of about, say, 5, about 5, not quite 5 percentage points, and the one on the right shows a drop of about 7 percentage points, maybe 8 over the same period. I just wonder if some of that drop might be explained by a tendency of more kids to not be admitting things when the parents have a very active group in the situation?

Mrs. RUSCHE. I don't think that's the case for a number of reasons. I think once parents' awareness rises to the level that Mel was describing to you in his community, where there were 25 active groups and they were so concerned they brought a treatment center into their community.

Once the parent's awareness is there, he can spot use and it's the parent who stops it. I was interested in these two young people because they made a point that I'm not sure was totally understood. Both of them said they were into drugs; they had fooled their parents for a while, but what got them out of drugs was that their parents took away some of their rights and forced them into treatment, in essence.

If their parents hadn't taken them down to straight, they wouldn't have gotten off drugs. I think that when a parent is willing to go through that much torment with his own child, you can't imagine what that means inside a family unless you've gone through it, but when a parent is willing to take that much heat and be that unpopular in his own family, he's not going to have the wool pulled over his eyes again.

Mr. SAWYER. Dr. Anderson, what's your view on the accuracy of self-reporting?

Dr. JOHNSON. We have certainly challenged the assumed validity of certain self-reported measurement techniques, not because we have strong evidence that people are reporting in a systematically biased way across all the various studies, but where we have looked at our own data, where we have collected biological samples in conjunction with self-reports, we first of all find a good deal of agreement between the biological samples and the self-reports, but we also find that collecting biological samples results in people reporting more drug use than if we don't collect the biological samples when they report.

At a ratio of about 2 to 1—that is, twice as many people reporting if the samples are collected, and in some cases, as high as 3 to 1. So it appears to us that there may be a self-report bias, a bias to present yourself in a favorable light, in a socially acceptable light.

As the bias has apparently increased over the last 4 or 5 years—looks like it has—that's happened at the same time that people are acknowledging that cigarette smoking and drug use is something that ought to be avoided.

So what I'm saying is that there seems to be an inconsistency between behavior and what they believe to be socially acceptable practices, and that may contribute to an increasing self-report bias.

I would say something about our findings, though. They've been replicated some places and not in others. Where people have failed to replicate, that is, where they find no difference when a person's reporting without giving biological samples, and when he is giving biological samples, there seems to be the belief among those researchers that they have established a good deal of rapport with respondents in their ongoing studies to gain the students' confidence.

So I think it is possible to get very good self-report measures. We just don't know very well what the conditions for that are right now. Any purely self-report measures I think you have to be somewhat careful about, especially if there's a change in self-report.

Mr. **Sawyer**. Apparently, as I understand what you're saying, the tendency or the bias toward not reporting has been tending to increase over recent years?

Dr. **Johnson**. There's some modest evidence that that's the case.

Mr. **Sawyer**. Would that—in your mind, how would that affect these, in your opinion, affect these page 11 charts? They're a relatively small percentage of drop, and it's all occurred in about the last 4 years.

Dr. **Johnson**. I believe in the paper that you have, I have data across that timespan of about 1977 to 1982 and it is, indeed, that period where there appears to be maybe a slight increase in self-report bias. There's no way to actually know to what extent that could or did contribute to the National Institute of Education studies, the NIDA studies, Dr. Johnston's studies.

There's just no way to tease that out. It is a possible explanation for some of the dip; it's not a certain explanation.

Mr. **Sawyer**. Very well. Thank you.

I yield back, Mr. Chairman.

Mr. **Hughes**. Thank you.

Mrs. **Rusche**. If I could just add something to that, I think we have two things with which to work, the surveys that chart national figures for us, but we also have our own experience in our own communities, and we know for certain, in our community, there are fewer kids smoking pot than there were in 1978. We also know that attitudinal change, I think, is important.

If you talk to kids in a community where there has been awareness and where there has been action, you will find a different set of circumstances from a community where that isn't—talk to the kids in both kinds of communities.

Mr. **Hughes**. Dr. Johnson.

Dr. **Johnson**. Could I make just one additional point? There is the belief, although this is not well documented yet, that the self-report bias is stronger with younger children, younger adolescents than with older adolescents. There may be a decrease in that tendency over time.

If that is the case, then I think Dr. Johnston's methodology may be relatively safe, that is, he is interviewing high school seniors and so he may find a lower self-report bias among that population.

Mr. **RIDDILE**. I've conducted a number of school surveys while working with the Department of Education's Region IV Alcohol and Drug Abuse Agency, and to the extent that we could guarantee the anonymity of each person and to the extent that we kept the surveys very limited in what we wanted to look for, we had higher consistency.

In other words, we had to take great lengths to guarantee their anonymity to get consistent reporting, and to have an extensive survey, such as the one that is done with 12th graders—and I would say that's a select group because you selected out the people that don't finish high school, and that can be anywhere in the community from 10 to 15 to 25 percent in some communities.

We all know, anybody who's been in education knows that those tend to be the heaviest drug users, so the figures are definitely conservative. I would agree that use has leveled off, but use is almost to the saturation point. When we have our—as a treatment director at this point—my biggest problem is when kids go back to school and they're drugfree, they feel so alone because they can't find other people that are drugfree.

That's the best testimony of where we are as a society; they can't find people to establish relationships with that don't use drugs, and I'm including alcohol as a drug now, that don't use alcohol and other drugs. These are people that are underage.

Mr. **HUGHES**. Well, it points up that we have a lot of work to do.

Let me just thank the panel because you've been of immeasurable help to us. You've given us some insights that I think will be very helpful.

I might say to you, Mrs. Rusche, we congratulate you on your work. Your organization has grown and prospered and you're doing great work. We commend you for it.

I'm familiar with your program, Doctor. I know that you have a couple youngsters from my community with your program. I know that a problem in my own community is first of all, getting parents to see the problem, and then facing up to it, and then knowing where to turn to get help.

So we appreciate the insights you've shared with us today. Thank you very much.

Mrs. **RUSCHE**. Thank you.

[Whereupon, at 2:30 p.m., the subcommittee was adjourned, to reconvene subject to the call of the Chair.]

APPENDIX

NIDA Capsules

Issued by the Press Office of the National Institute on Drug Abuse
5600 Fishers Lane, Rockville, Maryland 20857
301/443-6245

NATIONAL HOUSEHOLD SURVEY ON DRUG ABUSE

The following tables show the the percentage of Americans who have used drugs of abuse. These numbers were gathered in a nationwide survey of households conducted in 1982 for the National Institute on Drug Abuse by the George Washington University Social Research Group.

LIFETIME PREVALENCE OF DRUG USE: 1972-1982

	Youth: age 12-17						Young Adults: age 18-25						Older Adults: age 26+					
	'72	'74	'76	'77	'79	'82	'72	'74	'76	'77	'79	'82	'72	'74	'76	'77	'79	'82
Marijuana	14.0%	23.0%	22.4%	28.0%	30.9%	27.3%	47.9%	52.7%	52.9%	59.9%	68.2%	64.3%	7.4%	9.9%	12.9%	15.3%	19.6%	23.4%
Hallucinogens	4.8	6.0	5.1	4.6	7.1	5.2	-	18.6	17.3	19.8	25.1	21.3	-	1.3	1.6	2.6	4.5	6.6
Cocaine	1.5	3.6	3.4	4.0	5.4	6.5	9.1	12.7	13.4	19.1	27.5	28.7	1.6	.9	1.6	2.6	4.3	8.7
Heroin	.6	1.0	.5	1.1	.5	**	4.6	4.5	3.9	3.6	3.5	1.1	**	.5	.5	.8	1.0	1.1
Nonmedical Use of																		
Stimulants	4.0	5.0	4.4	5.2	3.4	6.5	12.0	17.0	16.6	21.2	18.2	18.1	3.0	3.0	5.8	4.7	5.8	6.4
Sedatives	3.0	5.0	2.8	3.1	3.2	6.1	10.0	15.0	11.9	18.4	17.0	18.8	2.0	2.0	2.4	2.8	3.5	4.8
Tranquilizers	3.0	3.0	3.3	3.8	4.1	4.8	7.0	10.0	9.1	13.4	15.8	14.8	5.0	2.0	2.7	2.6	3.1	3.6
Analgesics	-	-	-	-	3.2	4.2	-	-	-	-	11.8	12.7	-	-	-	-	2.7	3.3
Any Nonmedical Use	-	-	-	-	7.3	10.8	-	-	-	-	29.5	28.7	-	-	-	-	9.2	8.9
Alcohol	-	54.0	53.6	52.6	70.3	65.3	-	81.6	83.6	84.2	95.3	94.6	-	73.2	74.7	77.9	91.5	88.1
Cigarettes	-	52.0	45.5	47.3	54.1	[illegible]	-	68.8	70.1	67.6	82.8	76.3	-	65.4	64.5	67.0	83.0	78.6

- Not Available
** Less than one-half of 1 percent
Source: National Household Survey on Drug Abuse, 1982. National Institute on Drug Abuse.

CURRENT DRUG USE: 1972-1982

	Youth: age 12-17						Young Adults: age 18-25						Older Adults: age 26 +					
	'72	'74	'76	'77	'79	'82	'72	'74	'76	'77	'79	'82	'72	'74	'76	'77	'79	'82
Marijuana	7.0%	12.0%	12.3%	16.6%	16.7%	11.1%	27.8%	25.2%	25.0%	27.4%	35.4%	27.5%	2.5%	2.0%	3.5%	3.3%	6.0%	6.7%
Hallucinogens	1.4	1.3	.9	1.6	2.2	1.4	-	2.5	1.1	2.0	4.4	1.7	-	**	**	**	**	**
Cocaine	.6	1.0	1.0	.8	1.4	1.6	-	3.1	2.0	3.7	9.3	7.1	-	**	**	**	.9	1.2
Heroin	**	**	**	**	**	**	-	**	**	**	**	**	-	**	**	**	**	**
Nonmedical Use of																		
Stimulants	-	1.0	1.2	1.3	1.2	2.6	-	3.7	4.7	2.5	3.5	4.7	-	**	**	.6	.5	.5
Sedatives	-	1.0	-	.8	1.1	1.3	-	1.6	2.3	2.8	2.8	2.6	-	**	.5	**	**	**
Tranquilizers	-	1.0	1.1	.7	.6	.6	-	1.2	2.8	2.4	2.1	1.6	-	**	**	**	**	**
Analgesics	-	-	-	-	.6	.6	-	-	-	-	1.0	.9	-	-	-	-	**	**
Any Nonmedical Use	-	-	-	-	2.3	2.7	-	-	-	-	6.2	7.1	-	-	-	-	1.1	1.2
Alcohol	-	34.0	32.4	31.2	37.2	26.3	-	69.3	69.0	70.0	75.9	68.1	-	54.5	56.0	54.9	61.3	57.1
Cigarettes	-	25.0	23.4	22.3	~~[illegible]~~ 12.1	12.6	-	48.8	49.4	47.3	42.6	37.8	-	39.1	38.4	38.7	36.9	34.1

- Not Available
** Less than one-half of 1 percent
Source: National Household Survey on Drug Abuse, 1982. National Institute on Drug Abuse.

ANNUAL DRUG USE: 1972-1982

	Youth: age 12-17						Young Adults: age 18-25						Older Adults: age 26 +					
	'72	'74	'76	'77	'79	'82	'72	'74	'76	'77	'79	'82	'72	'74	'76	'77	'79	'82
Marijuana	- %	18.5%	18.4%	22.3%	24.1%	20.7%	- %	34.2%	35.0%	38.7%	46.9%	40.7%	- %	3.8%	5.4%	6.4%	9.0%	10.6%
Hallucinogens	3.6	4.3	2.8	3.1	4.7	3.6	-	6.1	6.0	6.4	9.9	7.3	-	**	**	**	.5	.8
Cocaine	1.5	2.7	2.3	2.6	4.2	4.3	-	8.1	7.0	10.2	19.6	18.5	-	**	.6	.8	2.0	3.8
Heroin	**	**	**	.6	**	**	-	.8	.6	1.2	.8	**	-	**	**	**	**	**
Nonmedical Use of:																		
Stimulants	-	3.0	2.2	3.7	2.9	5.5	-	8.0	8.8	10.4	10.1	11.0	-	**	.5	.8	1.3	1.8
Sedatives	-	2.0	1.2	2.0	2.2	3.6	-	4.2	5.7	8.2	7.3	8.4	-	**	.6	**	.5	1.4
Tranquilizers	-	2.0	1.8	2.9	2.7	3.0	-	4.6	6.2	7.8	7.1	5.9	-	**	1.2	1.1	.8	1.1
Analgesics	-	-	-	-	2.2	3.8	-	-	-	-	5.2	4.6	-	-	-	-	.5	1.0
Any Nonmedical Use	-	-	-	-	5.6	8.2	-	-	-	-	16.3	16.1	-	-	-	-	2.3	3.9
Alcohol	-	51.0	49.3	47.5	53.6	46.9	-	77.1	77.9	79.8	86.6	83.5	-	62.7	64.2	65.6	72.4	68.5
Cigarettes	-	-	-	-	13.3	14.2	-	-	-	-	48.7	41.1	-	-	-	-	39.7	37.3

- Not Available

National Household Survey on Drug Abuse, 1982—Summary of Selected Findings [1]

The 1982 National Household Survey on Drug Abuse among youth, young adults, and older adults indicates that since 1979 there has been a leveling off of the spread of marijuana use in the youth population, as well as a significant decline in the number of persons who currently use marijuana, alcohol, and various other drugs. By and large, the 1982 data represent a reversal of the upward trends in drug use charted by earlier surveys in this series throughout the 1970s.

MARIJUANA

The most recent data indicate a new stablization or even a slight decrease in the number of young persons who are now trying marijuana. For example, in 1982, the percentage of youth aged 12 to 17 who have ever tried marijuana (27 percent) is slightly lower than was the case for their counterparts in 1979 (31 percent) This slight decrease or leveling off is in contrast to the pattern set by the surveys of the 1970s; in those years, successive youth cohorts typically reported greater experience with marijuana.

Similarly, the percentage of young adults (age 18 to 25) in the current survey who say they have tried marijuana (64 percent) us slightly lower than was the case for their counterparts in the 1979 study (68 percent). Again, the slight decline represents a divergence from earlier trends, which showed an increase in lifetime prevalence from 48 percent of young adults in 1972.

The percentage of young persons reporting past-year use of marijuana decreased significantly between 1979 and 1982. For 12- to 17-year-olds, the decrease was from 24 percent in 1979 to about 21 percent in 1982. In the 18-to-25 age group, the decline was from 47 percent in 1979 to about 41 percent in 1982.

Trends in the "current prevalence" of marijuana use—that is, changes in the percent reporting use during the month prior to the survey interview—are more responsive to the most recent changes in patterns of behavior. Here, we find a more substantial decrease for youth as well as for young adults.

In the 1977 and 1979 surveys, nearly 17 percent of all 12- to 17-year-olds reported use during the month prior to interview; but by 1982 this figure had dropped to 11 percent. And whereas 35 percent of young adults reported past-month use in the 1979 survey (an all-time high), by 1982 this figure had dropped seven percentage points to 28 percent.

Current daily use of marijuana (defined as use on 20 or more days in the month prior to interview) also declined significantly among youth and young adults. For example, in 1979 almost 11 percent of all 18- to 25-year-olds reported that they had been daily users; by 1982 this figure had declined to about 7 percent. Frequent use of marijuana during the month prior to interview (defined as use on ten or more days out of the past month) also declined significantly between 1979 and 1982 for both youth and young adults.

Clearly, marijuana use peaked during the late 1970s, at least for the younger age groups in our population. Future surveys will show the extent to which the present downward trend in youthful marijuana use continues—if at all—throughout the decade of the 1980s.

The 1979-to-1982 declines observed for younger persons were not matched by declines in the population aged 26 and older. On the contrary, some increases in marijuana use were noted owing to the changing composition of this age group. Each year a new cohort of persons enters the "older adult" age category. In 1982, new entrants included many who first used marijuana as "youth" or "young adults" during the 1970s and who brought with them the newer forms of behavior. Thus, the experience of having used marijuana is no longer limited to the very young, and current use is no longer extremely rare among older adults. Nevertheless, when the youth, young adult, and older adult samples are combined, there is a significant decrease in current marijuana use among all persons aged 12 and older—from 13 percent in 1979 to 11 percent in 1982.

Finally, the downward trends in the younger age ranges should be viewed in light of the fact that many young persons have at one time or another used marijuana so intensively as to be at risk for negative consequences of drug use. A new measure included in the 1982 survey was directed toward the future study of marijuana consequences. This new indicator measures the *lifetime* prevalence of "daily" marijuana use—that is, the percentage who have ever used on 20 or more days in a single month.

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[1] From *National Household Survey on Drug Abuse*, 1982, National Institute on Drug Abuse.

Among young adults, the group at maximum opportunity for having experienced this level of use, about 20 percent report that at one time they used marijuana on a daily basis. This represents roughly one-third of all young adults who have ever tried the drug. Clearly, despite reduced levels of current marijuana use in 1982, many young persons do pass through one or more phases of concentrated use, and during this time they are at risk for various negative outcomes.

ALCOHOL AND CIGARETTES

Among 12- to 17-year-olds, the percentage who used alcohol during the month prior to the survey interview dropped from 37 percent in 1979 to 26 percent in 1982. Among young adults, aged 18 to 25, the drop was from 76 percent in 1979 to 68 percent in 1982.[2] Current "daily" use of alcohol (use on 20 or more days during the past month) also declined in the young-adult group—from, 10 percent in 1979 to 7 percent in 1982. This directly parallels the drop in current daily use of marijuana.

The prevalence of past month cigarette use among 12–17-year olds remained stable between 1979 and 1982, while among young adults (18–25 year olds) current prevalence dropped from 43 percent in 1979 to 38 percent in 1982. A similar decline for current use among older Americans (26 years and older) is also seen—37 percent for 1979 and 34 percent for 1982.

HALLUCINOGENS, HEROIN, COCAINE

Hallucinogens (including LSD, PCP, and peyote) followed the marijuana pattern of downward trends in the younger age ranges. Among young adults, the prevalence of current hallucinogen use went down from 4 percent in 1979 to 2 percent in 1982. The same pattern appears to hold for heroin, although low levels of reported use of this drug may reflect a tendency to deny stigmatized behavior. The 1979 to 1982 decrease may be be exaggerated due to the fact that the two Household Surveys were conducted at different times of the year.

With cocaine, the drug that spread most rapidly during the late 1970s, the pattern is now one of stability. This finding is especially clear in the young adult population, where lifetime experience with cocaine jumped from 13 percent in 1976 to 28 percent in 1979 and then leveled off at 29 percent. Similarly, past-month use in the 18–25 age group increased rapidly from only 2 percent or 3 percent in the mid-1970s to 9 percent in 1979, and then leveled off or decreased to about 7 percent in 1982.

In the older adult group, lifetime prevalence levels for hallucinogens and cocaine increased (as did past-year use of cocaine), a pattern that was expected because of the fact that birth cohorts who had begun use of these drugs during their young adult years are now moving into the 26-and-older category.

NONMEDICAL USE OF STIMULANTS, SEDATIVES, TRANQUILIZERS, AND ANALGESICS

When all four categories of nonmedical use are combined in a single index, 1982 lifetime and current prevalence levels for nonmedical use of prescription-type psychotherapeutic drugs are as follows: Among young adults, 29 percent have taken one or more of these drugs for nonmedical purposes, and 7 percent report having done so during the month prior to the 1982 interview. Among youth, 11 percent say they have used these drugs nonmedically, 4 percent doing so within the past month. Thus, for these age groups, as well as for older adults, prevalence of nonmedical use of drugs is comparable to the prevalence of cocaine use.

Recent trends in nonmedical use are difficult to assess because of a change in questioning technique. In all earlier surveys, questions on nomedical use of these pills were answered aloud in "open interview" fashion, along with questions on medical prescription use. In the 1982 survey, however, respondents checked off their answers to questions on nonmedical use, using private answer sheets comparable to those used for alcohol, marijuana, and other types of recreational drugs.

The observed 1979—1982 trends in nonmedical pill use include a general increase in lifetime prevalence figures for youth as well as an increase in the current use of stimulants in both the young and the young-adult populations. Because of the increased privacy of response in the 1982 survey, however, any actual change in prevalence levels, whether increase or decrease, is necessarily confounded with changes attributable to differences in reporting conditions.

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[2] Alcohol use remained steady from the early to mid-1970s. The appearance of a sharp increase between 1977 and 1979 may be explained at least in part by the change to the use of self-administered answer sheets for questions on alcohol use.

SPECTRUM OF DRUG USE: 1982

When the nonmedical use of psychotherapeutic drugs is combined in a single index together with the use of hallucinogens, cocaine, and heroin, it is found that about 40 percent of all young adults have had illicit experience with a least one substance other than marijuana; about 27 percent of this age group report past-year use of one or more of these "stronger" drugs. The corresponding figures for youth are: 14 percent tried one or more "stronger" drugs, and 10 percent have used during the past year.

SAMPLE SIZE AND POPULATION SIZE FOR AGE SUBGROUPS

[National Survey on Drug Abuse, 1982]

Age group	Sample size	Population size [1]
Youth (12-17 yrs)	1581	23,304,000
Young adults (18-25 yrs)	1283	33,072,000
Older adults (25 yrs +)	2760	126,105,000

[1] Source: U.S. Bureau of the Census.

Fort Lauderdale
News / Sun-Sentinel
Reprint of 7-part series, June 19, 1983 to June 25, 1983

The director of Florida's drug abuse services summed it up: "The public doesn't care very much about methadone patients. They don't enjoy a very good reputation, nor do they get much sympathy."

Indeed, the nationwide program to treat heroin addicts with methadone was not set up with the idea of doing something to help addicts. It was touted as a way to protect society, to keep addicts from committing crimes.

Small wonder, then, that for a decade the methadone program has been a neglected stepchild of the federal bureaucracy.

This series set out to do what the government's regulatory agencies should have done, but didn't—assess the merits of the methadone program as public policy.

Fort Lauderdale News and Sun-Sentinel investigative reporter, Fred Schulte, who spent a year on the project, found that methadone truly can be called "The Deadly Cure."

We'd like to share those findings with you.

Gene Cryan
EDITOR

A TRAIL OF DEATH

Methadone: The deadly cure

Addicts' medicine turns into a killer

Methadone, the drug pushed by Uncle Sam as the way to halt heroin addiction, has contributed to thousands of deaths during the past decade while becoming a significant drug of abuse in its own right.

Its victims include patients who sought a cure for their drug abuse, thrill-seekers who bought it on the streets, and unborn children carried by methadone-using mothers.

And each year, more narcotics abusers treated with methadone become trapped in a closed cycle of addiction, dropping in and out of treatment but never able to break completely free of the clinics that dispense this government-sanctioned, government-subsidized drug.

"Addicts are like modern-day lepers," said Dr. Vernon Patch, a Harvard Medical School psychiatry professor who directed Boston's methadone programs for seven years. "Addicts don't exist in sufficient numbers to give them a voting bloc, and they don't have a powerful lobby."

But the federal government accepted responsibility for the safety of patients treated with methadone in late 1972 when officials decided to approve the drug's use and help pay for its distribution, which has cost American taxpayers more than $1 billion.

After 11 years, no one knows the full extent of the injuries and deaths related to methadone. until the *Fort Lauderdale News* and *Sun-Sentinel* began a year-long review of the national methadone program, nobody even had an idea.

Government records disclose:

● Methadone alone killed at least 74 of more than 1 million patients who received it from clinics nationwide between 1973 and 1981, according to clinic reports. By contrast, Zomax, a non-narcotic painkiller, recently was removed from the market temporarily after it was learned that five deaths had resulted from 15 million prescriptions since late 1980.

● Methadone alone killed 558 people in 26 of the nation's largest metropolitan areas between April 1974 and November 1982, according to reports filed by medical examiners. These metropolitan areas include only about a third of the country's population, and flaws in the reports make it impossible to determine how many of the dead were clinic patients or how many obtained the drug illegally.

Methadone: The facts

● During the past 10 years methadone, alone or in combination with other drugs, has been responsible for the deaths of at least 4,417 people and has sickened at least 24,276 people so badly they required hospital treatment.

● The federal agencies that sanctioned the drug's use and supervised its distribution through tax-subsidized clinics have collected masses of information about the methadone program but never have analyzed the data to assess the treatment.

● The federal government approved methadone for use without requiring studies of its long-term health effects, even though the proposed maintenance therapy cuuld result in a patient taking the drug for years.

> **“The fact that methadone is given out by doctors has given the false impression that it is safe. Some of these treatment programs like to think that they are using an innocuous drug.”**
> **— Dr. Michael Baden, methadone opponent**

- The clinics reported that 1,037 patients died between 1973 and 1981 from drug-related causes, usually after mixing methadone with other substances. Methadone treatment is supposed to halt an addict's desire to abuse other drugs.
- Medical examiners' reports for the years 1974 through 1982 show that methadone was directly involved in 2,378 drug overdose deaths and was a contributing cause of 4,417 deaths in the 26 metropolitan areas. That's almost half as many as the 10,579 reported deaths linked to heroin, the principal drug methadone was intended to combat.
- The clinics reported that 6,237 of their patients between 1973 and 1981 suffered adverse reactions to methadone serious enough to require medical attention, but the government managed to record details of only 2,177 of those incidents. The detailed reports show 653 deaths, including 68 babies who failed to survive birth to methadone-using mothers.
- Big-city hospital emergency rooms reported that between April 1974 and November 1982, 24,276 people required medical care after taking methadone. At least a third of those emergency-room patients were treated for a drug overdose; just more than half of the total number of patients — about 13,500 — said they obtained the drug through a treatment program.

“The fact that methadone is given out by doctors has given the false impression that it is safe,” said Dr. Michael Baden, deputy chief medical examiner of Suffolk County, Long Island, and a longtime foe of the methadone program. “Some of these treatment programs like to think that they are using an innocuous drug.”

Federal officials told the *News* and *Sun-Sentinel* that they never have reviewed the thousands of reports piling up in their files of deaths and injuries linked to methadone.

“It's a question of resources,” said pharmacologist Frank Vocci, deputy chief of the FDA's drug abuse staff.

“We don't systematically review drugs like this,” said Vocci, whose agency is responsible for ensuring the safety and effectiveness of all drugs marketed in the country. “You are talking about tens of thousands of drug products; we can't do it for every drug.”

But one top federal official, Dr. Stuart Nightingale, FDA's associate commissioner for health, said the methadone-related deaths and injuries revealed by the *News* and *Sun-Sentinel* may indicate that the drug — or the way it is being used — no longer fulfills the legal requirement that it be safe and effective.

“When the drug was cleared for use [in December 1972] it met our standards,” Nightingale said. “The question is, what role does the medication have in the treatment process and at what point do the FDA standards change? That is a very difficult question.”

Nightingale said he believes the government has a duty to examine injuries linked to methadone more closely — particularly because the government is responsible for its widespread use.

“These cases obviously need scrutiny to see if there is a hidden problem here,” Nightingale said.

“This is an important area, and I am going to ask someone to look at it.”

If someone looks, it will be the first review since methadone went nationwide as a special project of the Nixon administration in 1972.

The impetus for the methadone program came from President Nixon, who on June 17, 1971, declared heroin addiction “Public Enemy No. 1” and vowed all-out war to eradicate it. Noting that crimes by addicts were soaring, Nixon told Congress methadone was a “useful tool” that “ought to be available” for use in rehabilitating addicts.

But Nixon's aides knew enthusiasm for methadone was not universal; public-health officials suspected large-scale dispensing of methadone could be dangerous because methadone is, after all, a narcotic. Just like heroin, it can produce euphoria, cause physical dependence when used repeatedly and kill if taken in large quantities or if combined with other drugs.

Mindful of those worries, Nixon promised that methadone programs “would be carried out under the most rigid standards and would be subjected to constant and painstaking re-evaluation of their effectiveness.”

Rigid standards were the rule when the methadone maintenance theory was tested on small groups of addicts under tight control of doctors and counselors; but once the federal government started dispensing the drug through crowded clinics, the job training and intensive counseling originally considered crucial in reforming addicts often were minimal.

“When methadone maintenance got too big, it lost the personal touch,” said Saul B. Sells, research director at Texas Christian University and the government's primary evaluator of the effectiveness of drug abuse treatment since 1968. “Methadone by itself won't rehabilitate anyone.”

“You will see deaths if the programs are not run tight,” said Dr. Herbert Kleber, a Yale University School of Medicine psychiatrist who operates a New Haven methadone clinic. “If a methadone program is run sloppily it is not a good program.

“It's not that methadone is bad,” Kleber said. “Methadone run badly hurts us all.”

Indeed, methadone administered properly may be an economical way to treat some addicts. Though few who try the treatment wind up free of drugs, some patients can stabilize on methadone and stop hustling or stealing to secure illegal drugs.

“For hard-core addicts, methadone maintenance is the most effective treatment that we know of,” said Dr. James Cooper, direc-

“These cases obviously need scrutiny to see if there is a hidden problem here. This is an important area, and I am going to ask someone to look at it.”
— Stuart Nightingale,
FDA official

tor of the Division of Medical and Professional Affairs of the National Institute on Drug Abuse.

But even the most vocal supporters of the therapy now concede its benefits were overstated at the start. Most treatment professionals now agree that changing drug abuse patterns — not methadone programs — were primarily responsible for the steady decrease in heroin deaths through the mid-1970s. As higher-quality heroin returned to the nation's streets in the early 1980s, heroin deaths again began to increase.

In the decade since methadone went nationwide, more than $1 billion in federal, state and local tax money has been spent to distribute the synthetic narcotic through a network of treatment clinics across the United States. Another $50 million has been spent to improve treatment methods, inspect clinics and collect statistics — but most of those statistics never were used by the bureaucracy to evaluate methadone.

The *News* and *Sun-Sentinel*'s examination of the methadone program involved the study of tens of thousands of pages of documents, statistics and computer reports, most of which had to be pried out of reluctant agencies of the federal Department of Health and Human Services by use of the Freedom of Information Act.

One of the first things the newspapers learned was that the government's information about the methadone program is far from complete. Many reports are inconsistent and riddled with obvious errors; more than a year's worth of data escaped collection because bureaucrats changed reporting periods repeatedly; and on average 13 percent of methadone clinics each year ignored regulations requiring them to inform the government of adverse reactions to methadone.

The DEA's Drug Abuse Warning Network (DAWN) is perhaps the most comprehensive measure of methadone-related deaths and injuries, but DAWN collects reports only from 26 major areas — Standard Metropolitan Statistical Areas — which include about a third of the country's population. There were 283 such statistical areas nationwide during the years of the DAWN reports.

In the 26 areas covered by DAWN, the agency estimates that only 68 percent of medical examiners and 79 percent of hospitals file reports with DAWN.

And those reports are far from complete. For example, nearly half of the medical examiners' reports do not indicate whether a victim of methadone was enrolled in any type of rehabilitation program.

The situation in South Florida demonstrates what DAWN is missing: Dade County, the only area in Florida covered by DAWN, reported 16 methadone-related deaths in 1980 and 1981; the *News* and *Sun-Sentinel* discovered 12 methadone-related deaths in the same two years in Broward County — deaths that do not show up in DAWN's methadone death count of 4,417.

Federal officials have considered the DAWN system a reliable indication of heroin abuse but have criticized its accuracy in chronicling methadone abuse, claiming the reports do not always establish that methadone actually caused death. In most cases, methadone is determined to be a contributing factor to death because other drugs usually are present in the body.

But those officials fail to mention that most heroin deaths also involve other drugs. Since 1974, overdose deaths linked to heroin by the DEA have involved other substances in about 80 percent of cases; methadone mixed with other drugs has proved fatal in roughly the same percentage of cases, according to DEA records.

The bureaucracy also has tried to ignore the seriousness of medical problems caused by methadone abuse. In 1978, a coalition of government officials claimed in testimony before a Congressional committee that most methadone-related emergency-room visits were by clinic patients with minor ailments, frequently poor people who used hospital emergency rooms instead of private doctors.

But DEA reports show that about one of every three methadone-related emergency-room patients were incoherent, unconscious or dead on arrival — hardly an indication of minor ailments.

Government regulators also have failed to evaluate 1,037 deaths reported to FDA between January 1973 and December 1981 by methadone clinics — deaths which the clinics stated were due primarily to "methadone in combination with other drugs."

FDA officials also have no way of knowing whether these patient death reports are complete, or how it was determined that methadone was related to death. No one ever has tried to compare the reports to the clinics' records. Because federal officials switched reporting periods four times, 13 months of data never was collected.

From May 1, 1977, to April 30, 1978 — the last year the programs were required to report total patient deaths — methadone clinics across the country reported 788 patient deaths. About 9 percent of them were said to be due to methadone mixed with other drugs. The government never asked what caused the other deaths.

The government also is unable to

account for records of numerous deaths and other adverse reactions through the years, either because FDA lost reports or clinics failed to supply details.

Officials of the NIDA and others frequently have defended the methadone program by arguing that addicts are far more likely to die if left untreated. Yet most attempts to determine mortality for both methadone patients and untreated addicts are based on crude guesswork, largely because nobody knows how many drug addicts there are.

In 1970, one New York researcher reported that he found no difference in death rates between a sample of addicts treated with methadone and those remaining "on the street." Both groups studied showed a death rate of 13 per thousand per year from all causes.

In 1979, NIDA officials described the death rate for untreated addicts as 13 per thousand yearly in written testimony submitted to a Senate committee. Officials did not say how the death rate was calculated, nor did they include estimates for methadone patients.

In October 1980, the New York State Division of Substance Abuse Services, which treats addicts primarily with methadone, reported the death rate for heroin addicts in treatment was 14 per thousand per year. Based on estimates of the total number of addicts in the state, the division concluded that 25 per thousand per year not in treatment died.

One of NIDA's data systems suggests that addicts in methadone maintenance programs may run a higher risk of death during treatment than patients in any other type of therapy.

That data system, the Client Oriented Data Acquisition Process (CODAP), gathers statistics from NIDA-funded drug treatment clinics — about 60 percent of the methadone-dispensing clinics across the country.

CODAP annual reports from 1977 to 1981 show that an average of 12 of every 1,000 addicts listed as "discharged" from methadone maintenance died while still enrolled in an outpatient program. By contrast, only three of every 1,000 addicts "discharged" from outpatient programs that did not use methadone died while still enrolled.

The CODAP reports include deaths from all causes and are not compiled separately by cause of death. Nor do the reports provide a total number of patients enrolled in the various types of therapy, making calculation of a mortality rate impossible.

NIDA officials speculated that addicts placed in maintenance treatment are more likely to have longstanding records of violent behavior, which could explain higher death rates. They conceded, however, that no documentation is available to substantiate that speculation.

"The real truth is that we don't know the mortality rate for methadone patients," said Dr. James Ruttenber, a medical epidemiologist with the federal Centers for Disease Control in Atlanta.

"A lot of people in government don't care about this," Ruttenber said. "It is not a high priority, but if the government is giving out a drug that is so controversial, it should be following it more closely."

METHADONE DEATHS

	NUMBER OF PATIENTS IN TREATMENT DEC. 31	DEATHS DURING YEAR
CALIFORNIA		
San Diego Health Alliance, San Diego	97	3
C Street Community Clinic, San Diego	220	2
San Diego Health Alliance, San Marcos	75	2
FLORIDA		
St Luke's Center, Miami	270	3
Broward Meth. Maintenance, Hollywood	280	2
ILLINOIS		
Center for Addict Problems, Chicago	404	2
LOUISIANA		
Drug Research Clinic, New Orleans	216	3
MICHIGAN		
Care Clinics, Detroit	235	2
MISSOURI		
DART, St. Louis	150	4
NEW YORK		
Bronx State Hosp. (Trailer I), Bronx	294	5
Harlem Hospital Unit III, New York City	334	3
Health and Hosp. Corp., Elmhurst	289	3
Psych. Services Center, White Plains	198	3
Peekskill Community Hosp., Peekskill	165	2
Nassau County, East Meadow	282	2
OREGON		
C.O.D.A., Portland	279	2
PENNSYLVANIA		
Achievement Through Counseling, Phila.	237	3
Mantua Halfway House, Philadelphia	187	2

SOURCE: U.S. Food and Drug Administration, individual Annual Reports for a Treatment Program Using Methadone.

Chart shows methadone clinics reporting more than one patient death due at least in part to methadone in 1981. Thirty-eight other clinics, including the Veterans Administration Hospital in Miami and the Pompano Methadone Treatment Center in Pompano Beach, reported one death each during the year. Overall, 86 methadone patients died during 1981 — 9 percent more than in 1980.

Narcotic was seen as heroin 'cure'

Methadone, a synthetic narcotic, was created by German chemists to alleviate a shortage of morphine during World War II. Its use was limited in the United States until 1966, when a New York obesity researcher, Dr. Vincent Dole, began touting methadone as a way to cure heroin addicts.

According to Dole's theory, methadone would replace heroin in an addict's body. Patients would become physically addicted to methadone, but they could obtain the drug daily at government-monitored clinics and would not have to commit crimes to get heroin.

The addict would be maintained on a steady daily dose of methadone while receiving counseling and job training through the clinics; the daily dose would be reduced gradually until the patient eventually was drug-free.

During the following five years a growing number of doctors began treating addicts with methadone, ostensibly as part of research programs. Then in 1971, a special office in the Nixon White House adopted methadone as the cornerstone of a national drug abuse treatment program to battle a "crime wave" caused by heroin addiction.

Eventually the White House office was closed and the methadone program was turned over to the federal bureaucracy, where it kept going and growing — and was largely ignored.

"The public doesn't care very much about methadone patients," said Frank Nelson, director of drug abuse services for the Florida Department of Health and Rehabilitative Services. "They don't enjoy a very good reputation, nor do they get much sympathy."

Nixon ignored methadone warnings

Early tests showed drug could be lethal

Political appointees in the Nixon administration set up the national methadone program in the early 1970s even though they had indications that the drug already had caused hundreds of deaths and had failed to reform most addicts.

The nation's top health official warned President Nixon that methadone abuse would be impossible to halt.

"My own view is that embarking on a national program of methadone maintenance may court potential disaster," wrote Elliot Richardson, then secretary of the U.S. Department of Health, Education and Welfare, in a March 19, 1971, memorandum to Nixon.

"We would be forced into a posture of pushing this program without the support of a generally accepted consensus of scientific knowledge and in the face of the judgments of our professional advisers," Richardson wrote. "All of the professional agencies involved are extremely wary of a greatly expanded federal emphasis on methadone maintenance. Their fears ... must be treated with great respect."

But Nixon took responsibility for all drug abuse treatment away from the public-health establishment and gave it to a new office in the White House — with specific instructions to set up a methadone program.

The *Fort Lauderdale News* and *Sun-Sentinel* learned that numerous advance warnings of methadone's dangerous shortcomings — including studies by four federal agencies — were disregarded by White House officials.

Methadone maintenance was new, a program that could be set up as evidence that the government was doing something about street crime. Nixon, after all, was up for re-election in 1972, and crime spawned by heroin addiction was shaping up as one of the major issues of his campaign.

"Narcotics addiction is a major contributor to crime. The cost of supplying a narcotic habit can range from $30 to $100 a day, $10,300 to $36,000 a year," Nixon wrote in a June 1971 message to Congress. "Untreated addicts do not ordinarily hold jobs. Instead they often turn to shoplifting, mugging, burglary, armed robbery and so on. They also support themselves by starting other people — young people — on drugs."

The *News* and *Sun-Sentinel* traced the genesis of the methadone program by examining thousands of documents generated by Nixon's Special Action Office for Drug Abuse Prevention (SAODAP). "Few, if any" persons outside government have reviewed the records, which are housed at the National Archives in Washington, officials said.

The SAODAP records disclose that there was plenty of evidence about methadone's shortcomings:

- A March 1971 review of drug abuse programs operated by the National Institute of Mental Health — a study the White House labeled "administrative confidential" — found that 41 percent of methadone patients continued to use heroin and that methadone patients were arrested more frequently than those in other forms of treatment.
- In July 1971, top Food and Drug Administration officials told their White House counterparts that the FDA had failed to halt "gross problems" of methadone diversion and "failed to ensure quality control" in methadone research programs.
- A confidential, 21-city study showed that during 1972, when methadone programs were expanding rapidly, methadone was involved in 164 deaths, twice as many as the previous year and 22 percent of all narcotics overdose deaths in the country.

Nixon chose Chicago psychiatrist Dr. Jerome Jaffe to run the new federally financed drug abuse treatment system.

Jaffe, who now is a professor of psychiatry at the University of Connecticut School of Medicine, was a strong proponent of methadone then and still believes the methadone program was a good idea.

"I don't have any second thoughts on whether it was appropriate to decide that methadone should be available for people who need it," Jaffe said in a telephone interview.

"It was my responsibility to make the final decision [to proceed with methadone], and I did it my way," he said.

Jaffe's way was single-minded; he and others at SAODAP had little patience with anyone who was not committed to the methadone initiative.

Dr. Bertram Brown, who was director of the National Institute of Mental Health at the time, came under fire for urging a closer look at methadone in an Oct. 20, 1971, hearing before the House Armed Services Committee.

Jaffe later wrote in a memo that Brown's testimony "directly took issue with either administration-backed legislation or policy ... [and] spoke somewhat disparagingly of methadone maintenance." Brown had "deliberately undercut the President," Jaffe wrote.

"Pressure for a panacea overrode the lack of scientific data," Brown recalled. "To argue caution was treason."

Another government scientist, Dr. Barry Festoff of the National Institutes on Neurologic Diseases, became the subject of a SAODAP memo after he attended an anti-methadone meeting in Baltimore.

"Dr. Festoff's negative comments on the use of methadone

With President Nixon at 1971 press conference announcing formation of Special Action Office for Drug Abuse Prevention are, from left, Egil "Bud" Krogh Jr., chief assistant to John D. Ehrlichman; Dr. Jerome Jaffe, Nixon's appointee as director of the new White House office; and Ehrlichman, assistant to the president for domestic affairs.

maintenance tend to undermine the official policy position enunciated by SAODAP," wrote SAODAP Communications Officer Henry Cox to Deputy Director Paul L. Perito. "Clearly, we can't have U.S. gov't personnel publicly expressing views which are in opposition to official policies or programs. Dr. Festoff should be reminded that as a U.S. government employee he has no 'personal' views, but must support official policy when he appears on a public platform."

Nixon aides felt they faced an emergency that left no time for scientific debate: They were fighting a heroin "epidemic."

Heroin addiction "has moved from the ghetto to the suburbs, from the poor to the upper middle class," Nixon told a June 22, 1971, meeting of the American Medical Association. "It spreads like a plague throughout our society."

In March 1971, 11,000 people were receiving methadone — all through research programs, because the drug had not yet been approved to treat addicts. Jaffe's plan called for expanding to 50,000 patients once the drug was approved, but that number was surpassed well before then. By the start of 1973, when methadone was cleared for use, 57,000 addicts were enrolled in methadone treatment; by January 1974, there were 108,000.

Jaffe retained an interest in ensuring that methadone treatment was helping drug abusers, but some White House aides envisioned the program as a way to enhance the president's political fortunes.

Assistant to the President for Domestic Affairs John Ehrlichman and his deputy, Egil "Bud" Krogh, to whom Jaffe reported, spoke of benefits to "society" from the programs — mostly that crime might recede.

During the press briefing announcing Jaffe's appointment, Krogh, commenting on the District of Columbia's Narcotic Treatment Administration program, said:

"After a year we found that those in high-dosage methadone ... had a marked decline in criminal recidivism. They were able to hold jobs, stay with their families."

Krogh went on to claim that methadone was partly responsible for a "correlative decrease of 5.2 percent" in the district's crime rate; however, he admitted he didn't know just how much methadone had to do with the decrease.

In fact, there were indications that methadone was no more effective in reducing crime than therapy which stressed abstinence from drugs.

A March 1971 study of programs operated by NIMH, which at the time was treating 3,000 patients with methadone, stated that "methadone patients are arrested no less often [than patients in other treatments] and spend just as much time in jail."

If methadone's effect on crime was unclear, it was obvious that the drug was leaving a trail of death.

In 1971, heroin was associated with 60 deaths in the District of Columbia compared to 17 for methadone; during 1972, the year that methadone enrollment soared, methadone contributed to 33 deaths, compared to 20 linked to heroin, and an additional 18 deaths were linked to a mixture of methadone and heroin, according to D.C. Medical Examiner Dr. James Luke.

Methadone casualties were not limited to the nation's capital. A study titled "Methadone Involvement in Narcotic Related Deaths," which showed that methadone had a role in 22 percent of narcotics deaths in 21 major cities during 1972, was completed by SAODAP's Systems Division in 1973. The report, which associated methadone with 282 deaths, also was suppressed under the label "administrative confidential."

"They didn't give evidence of methadone deaths the proper weight because they were committed to this way of treating people," said Brown, now president of Hahnemann University in Philadelphia. "Methadone was their magic solution."

SAODAP and other government agencies repeatedly failed to launch a detailed review to determine if methadone deaths could be prevented. Three proposals to study the problem were rejected between October 1971 and April 1973.

Steady reports of deaths and injuries related to methadone did cause some dissent within SAODAP, but the agency's official position was to ignore the reports — "studied silence," SAODAP official Dr. Roger E. Meyer dubbed the response in a Feb. 10, 1972, memo — until Congress authorized money for methadone maintenance and other drug abuse treatments.

But Meyer worried the stonewall might "backfire" and result in the program being "discredited" if SAODAP took no action against methadone abuses: "Continued silence, by implication, tends to support the view that this office is not concerned about the quality of therapeutic services being offered," his memo reads.

On March 16, SAODAP official Dr. Alan I. Green noted in a memo that methadone deaths had reached "scandal" proportions in Boston; he warned that "the actual existence of methadone as a useful treatment modality may be jeopardized."

But on March 21, 1972, Congress unanimously authorized spending nearly $200 million for drug abuse treatment.

FDA solicited work on drug, then OK'd it

Swift approval of methadone as a treatment for narcotics addiction was assured because the government agency that would authorize the drug's use had solicited its development.

"The government got everybody together, and the government pushed [methadone] through the system," said Dr Jerome Jaffe, an early methadone advocate who directed President Nixon's Special Action Office for Drug Abuse Prevention.

Federal law requires that the Food and Drug Administration determine a drug is "safe" and "effective" for treating a specified ailment. Drug companies conduct years of tests, first in laboratory animals, then in humans.

But after the government asked one company to manufacture a form of methadone for addiction treatment, it exempted the company from some test requirements.

"The trials for methadone were not of the grade required to get a drug approved," said Dr Jack Blaine, a former research psychiatrist with the National Institute on Drug Abuse. Blaine called the testing "inadequate and incomplete."

Approval "was done with the knowledge that we didn't know effects of chronic use of methadone, but we did know addicts were killing themselves with heroin," said Dr. Edward Tocus, a pharmacologist who heads FDA's drug abuse staff. "The purpose of methadone was to get the addicts off the street and maintain their addiction so that they didn't need to steal to get heroin or go into withdrawal."

Jaffe said FDA received adequate study material to justify approval of the drug. Though he conceded that some proponents overstated the drug's benefits, he insisted methadone was effective.

"[Effectiveness] is a pass/fail system. How effective is irrelevant," Jaffe said.

Methadone had been in use as a painkiller and cough syrup since 1947. Eli Lilly and Co., of Indianapolis, was the primary American manufacturer of the drug, which also had been used to wean addicts from heroin at the U.S. Public Health Service Hospital in Lexington, Ky.

In 1963, New York researchers Vincent Dole and Marie Nyswander conceived a new use for the drug — long-term maintenance of addicts on high doses, to keep them from using heroin. Dole surmised that addiction was a metabolic disorder like diabetes; giving addicts methadone, he reasoned, was no different than supplying a diabetic with insulin.

> **"We didn't know effects of chronic use of methadone, but we did know addicts were killing themselves with heroin."**
> **— FDA's Dr. Edward Tocus**

Their research results, published in 1965 and 1966, claimed that 85 percent of their patients had been rehabilitated, largely because methadone "blocked" the effects of heroin.

Dole's claims that addicts maintained on methadone could get jobs and seek rehabilitation were greeted with some skepticism among drug treatment specialists, but he excited politicians.

Methadone's potential to reduce crime first received widespread attention during John Lindsay's 1968 campaign for re-election as mayor of New York City. Lindsay touted methadone maintenance as the way to keep the city's estimated 200,000 heroin addicts from stealing to feed their habits.

Shortly thereafter, the federal government became interested.

Government documents obtained by the *Fort Lauderdale News* and *Sun-Sentinel* disclose that FDA officials placed the agency in the unusual position of urging the manufacture of a drug whose use the agency later would have to approve.

In 1969, Dr. Robert Ley, commissioner of the FDA, arranged a meeting between Dole and Eli Lilly scientists to discuss development of a form of the drug suitable for large-scale dispensing to addicts.

In March 1970, top FDA officials worked out a deal with Lilly to produce a methadone tablet and to collect research data showing that methadone would be safe. Lilly agreed to compile a New Drug Application, a document that is the basis for FDA approval or rejection.

Lilly had done no research on methadone's use as a maintenance drug; the government arranged to have Dole and Jaffe, then a White House consultant, supply their records.

Jaffe said he was unaware of the role he would play in the Nixon administration when he agreed to provide records of patients treated at his Chicago clinic.

On June 17, 1971, Nixon appointed Jaffe to head the new Special Action Office for Drug Abuse Prevention (SAODAP) and set up a national drug abuse treatment system. During 1970, Jaffe had chaired a presidential commission that recommended a national methadone initiative.

Twelve days after Jaffe's appointment to the White House post, Eli Lilly submitted its New Drug Application to FDA. Jaffe called the timing a "coincidence."

Instead of the results of 8 to 10 years of tests on animals, tests on humans, and clinical trials that approximate actual conditions under which the drug would be used, Lilly's application contained reports on five years of human testing. Jaffe's research was part of the application.

"In retrospect, I'd say that we had enough information at the time that it was a reasonable scientific risk to expand methadone," said Dr. Herbert Kleber, a Yale University professor who conducted safety tests on methadone after the drug was marketed.

But as early as December 1970, the National Institute of Mental Health had expressed concern that methadone "not be adopted uncritically and that there be adequate evaluation of all aspects."

FDA had expressed some doubts in April 1971 when the agency published guidelines for "investigational" use of the drug. But that opposition softened quickly after Nixon endorsed a national methadone program.

An FDA draft policy statement dated Oct. 28, 1971, repeated the agency's concern that "chronic toxicity studies are needed to establish the safety of such long-term use," but also noted that "in view of the benefits attributable to methadone and the tremendous social problems associated with narcotics problems, the Commissioner of the FDA finds that it is not in the public interest to withhold the drug from the market until further studies have been completed."

On Nov. 8, 1971, FDA officials in Congressional hearings announced they would approve methadone as soon as regulations on its use could be written.

There was another practical reason for approving methadone: FDA had allowed hundreds of physicians to administer the drug in so-called "research" programs; government records show that as early as September 1971, FDA officials concluded the agency was in "potential violation" of federal law because few of these physicians qualified as researchers.

In those "research" programs, 10,000 people had become addicted to methadone; no official wanted to face the prospect of mass "cold turkey" withdrawal.

"The alternative was to tell thousands of people that they couldn't use methadone anymore," Blaine said.

Before methadone won final approval, Jaffe's and Dole's research came under attack.

Jaffe's Illinois operation, where methadone was used to treat 547 addicts, was criticized in a draft General Accounting Office report dated March 14, 1972:

"The Illinois Drug Abuse Program has not evaluated either the effectiveness of the program overall or the relative effectiveness of the various treatment approaches in terms of progress toward the primary treatment goal," reads the report.

And Dole's original conclusions were branded "ambiguous and exaggerated" by San Antonio physicians James Maddux and Charles Bowden, at the May 1972 annual meeting of the American Psychiatric Association. They charged Dole's claims for methadone's effectiveness were distorted because his studies excluded patients who dropped out before completing treatment.

Others argued that Dole's results were based on groups of closely monitored, highly motivated patients, the sort who always did well in drug treatment programs. They said the government would find a different story when the technique was applied to masses of addicts, some of whom would be given the choice of accepting methadone treatment instead of jail time for crimes they had committed.

The third stage of normal drug approval trials, designed to mimic as closely as possible the conditions under which a drug would be used, is supposed to resolve that uncertainty. Some drugs are denied approval because FDA officials find that safety and effectiveness drops substantially in these "Phase III" trials.

Most drug abuse authorities, both inside government and out, agree that the effectiveness of methadone treatment declined dramatically once the drug was available to any licensed physician willing to apply for a government permit.

A federally sponsored study of long-term effects of methadone didn't begin until 1973. The findings of that three-year study were not published by the National Institute on Drug Abuse until 1980.

That study indicated methadone caused "no significant side effects" in the sample — but the researchers added that they could not "rule out [the] possibility" of side effects, mainly because the patient sample was relatively small.

"My experience has been that the methadone programs have not been looked at in a scientific way," said Dr. James Ruttenber, a medical epidemiologist with the federal Centers for Disease Control in Atlanta.

"The people that run these programs are not malicious, but they have no idea whether they are doing more harm than good," he said.

Methadone: The facts

● The federal government's attempt to protect patients from poor care by methadone clinics — at best a half-hearted effort — has been slashed to an all-time low during the past two years.

● During the past 10 years methadone, alone or in combination with other drugs, has been responsible for the deaths of at least 4,417 people and has sickened at least 24,276 people so badly they required hospital treatment. At least 68 of the fatalities were unborn children carried by methadone-using mothers.

● The federal agencies that sanctioned the drug's use and supervised its distribution through tax-subsidized clinics have collected masses of information about the methadone program but never have analyzed the data to assess the treatment.

● The federal government approved methadone for use without requiring studies of its long-term health effects, even though the proposed maintenance therapy could result in a patient taking the drug for years.

A REGULATORY NIGHTMARE

Lax controls cost lives

Watchdog agencies ease off

Methadone has proved a useful drug as dynamite has proved a useful explosive, but both must be handled with extreme care or they can hurt more than help.

— Food and Drug Administration publication, September 1973

For nearly a decade, the federal government's attempt to protect methadone patients has been half-hearted; now, the government nearly has given up trying.

Even though the number of patients receiving the potentially deadly drug is growing, regulation of the nation's methadone treatment programs has been slashed to an all-time low because of budget reductions and reluctance to spend time on programs that generate little support.

"The addict has no constituency, no congressman that watches out for his interests," said Daniel P. Hillstrom, deputy director of the U.S. Food and Drug Administration's Division of Methadone Monitoring. "Methadone monitoring is a matter of priorities, and methadone has been losing priority in recent years."

The FDA Center for Drugs and Biologics, of which the methadone monitoring division is a part, ranks that division dead last in a priority list of functions in its proposed budget.

FDA officials said the agency has never believed its resources should be devoted to inspecting drug treatment programs and ensuring that clinics followed agency safety regulations. The regulations are "minimal" standards, far less strict than numerous professional medical groups have recommended through the years.

Even when FDA inspectors regularly turned up serious, and repeated, violations of the standards, the agency seldom took strict action.

"Although there is sufficient evidence of various cases to warrant closing the programs, the FDA has been reluctant to take action," read minutes from a White House meeting on Feb. 27, 1973.

Government officials now claim they have tried to keep even the poor programs operating, because they feared closing them would hurt patients and lead to increased crime.

"Taking action against a methadone program is very political," said Harold Dieter, director of the Drug Enforcement Administration's Bureau of Compliance in Miami. "People start screaming that the crime rate will get worse."

The politics revolving around methadone is clear in other ways. "FDA depends on inspections of methadone treatment programs to uncover violative programs," Dr. J. Richard Crout, director of the FDA's Bureau of Drugs, stated in testimony submitted to the House Select Committee on Narcotics in April 1978.

Three years later, under a different administration, the agency drastically cut back its effort to review clinics.

In December 1981, FDA eliminated contracts with Florida and four other states to perform surprise clinic inspections and cut back its inspections in other states. In fiscal 1977, when 680 methadone clinics were operating, 325 inspections were performed nationwide; during fiscal 1982, when there were 583 clinics, only 116 inspections were done. This year's review schedule is uncertain.

The FDA decision to rescind inspection contracts has forced some states to greatly reduce monitoring. In New York state, where more than 32,000 people are on methadone treatment, officials said loss of the contract would mean 50 percent fewer inspections could be made.

Before the decision to eliminate inspections, the FDA had planned to review all 14 Florida methadone programs in 1982. Only one inspection was done.

“Taking action against a methadone program is very political. People start screaming that the crime rate will get worse.”

— Harold Dieter, of DEA's Miami bureau

Hillstrom, asked if the limited inspection program would be effective, said: "I hope so, but I have my doubts."

FDA officials conceded their enforcement efforts have decreased. But when figures showing a 66 percent reduction in these efforts during part of fiscal 1982 were made public by the consumer lobbying group Public Citizen, FDA officials insisted "voluntary compliance" has improved.

The federal agency has yet to resolve the future of the inspection program, but Hillstrom said reviews probably will be performed on a "for cause" basis on programs the agency believes may be violating rules. He did not specify how the agency would learn of violations if no inspections are performed.

In Florida, the state Department of Health and Rehabilitative Services is trying to pick up where the federal inspections left off. Yet HRS' lone inspector reviewed just seven of the state's programs during 1982. His reviews are less thorough than federal inspections because fewer records are chosen for review, and the frequency of inspection is limited by the agency's other duties.

"FDA has reduced its efforts drastically," said Frank Nelson, HRS director of drug abuse services in Tallahassee. "The inspections were stricken without a lot of thought to what the consequences might be."

In addition to greatly reducing clinic inspections, the government has considerably watered down some of its regulations designed to ensure patient safety.

In September 1980 the government relaxed rules on testing patients for unauthorized drug use, allowed more patients to take home more doses for unsupervised consumption, and reduced requirements for physician and staff coverage at methadone clinics.

Requirements for urine tests to detect potentially fatal drug abuse have been reduced for most patients to eight tests a year instead of one a week. Many programs had argued that the tests are expensive to perform and can be inaccurate.

In a dual agency opinion, the FDA and the National Institute on Drug Abuse said testing requirements had been revised because weekly screening "may not represent the best use of fiscal resources." The ruling also stated that inaccurate test results might cause clinic personnel to discipline patients without cause, which might "adversely affect a client's progress in treatment."

But some program directors said relaxing the requirements increased the "danger of drug overdose" for methadone patients according to FDA records.

The decision to ease take-home restrictions was purely one of convenience.

The FDA originally imposed tough restrictions on take-home methadone because it feared that some patients would sell methadone on the street if given a chance to do so. But the agency received — and approved — so many requests for exceptions to the rules that by 1980 officials relaxed the standards.

FEWER WATCHERS WATCHING

Year ending Sept. 30	Workers	Budget
1976	65	$1.8 million
1977	65	$2.2 million
1978	65	$2.4 million
1979	57	$2.1 million
1980	32	$1.5 million
1981	32	$1.5 million
1982	17	$1.1 million
1983	18	$748,000
1984*	18	$675,000

*PROPOSED

SOURCE: U.S. Food and Drug Administration.

Resources devoted to FDA's Division of Methadone Monitoring have declined steadily since 1978.

FDA's safety regulations have divided methadone treatment specialists for years. Some argue that physicians, not government bureaucrats, should decide when to test urine and allow take-home privileges to patients. Some specialists blame restrictive regulations for the failure of methadone clinics to rehabilitate most addicts.

Consequences of the easing of safety standards and the decline in inspections are not clear. Methadone monitoring officials conceded they had not even planned to evaluate national treatment data for 1981 until the *News* and *Sun-Sentinel* sought the data under the Freedom of Information Act, and treatment statistics for 1982 have not even been collected from clinics.

In fact, the government's effort to collect information about all drug abuse and treatment nationwide has been crippled because data systems have been scaled back drastically or eliminated.

A data bank called the Client Oriented Data Acquisition Process (CODAP) formerly required federally funded treatment programs to report patient information ranging from drugs used at admission to reasons for discharge. Participation became voluntary in 1982, and more than half the treatment units promptly dropped out, including such large-volume states as New York and California. The system is the only compilation of the drugs that bring people into treatment — a measure many experts consider crucial to planning treatment priorities and drug abuse prevention campaigns.

"Sure it bothers us," Josell Gatrell, an NIDA contract officer, said of the changes. "It's hard for us to find out what is happening in drug abuse treatment."

Another NIDA system called National Drug Abuse Treatment Utilization Survey (NDATUS), which collected statistics on all types of drug treatment programs, has been abolished. The system was the government's only means of determining enrollment and costs of drug abuse treatment.

Finally, the Drug Enforcement Administration's Drug Abuse Warning Network (DAWN), while still active, was scaled back in 1981, even though $3.6 million was appropriated to run the system through 1984. Since 1973, the DAWN system has compiled statistics on drugs that kill or injure people in major metropolitan areas across the country.

Drug has hurt, killed babies

Jennifer is a thin, pale little girl who has impaired vision and uncontrolled eye movement. Parents for Jennifer will need to be accepting of her delayed development and the impossibility of predicting Jennifer's future level of achievement.

— South Florida adoption agency notice, October 1981

Five months after her birth in May 1979, Jennifer became a ward of the state. The frail baby was discovered by police during a drug bust at a communal residence where her mother had left her — apparently for good.

"The doctors said she had brain damage as a result of her mother taking methadone," said Kathleen Deal, an adoption counselor for the Broward County office of the state Department of Health and Rehabilitative Services.

It took HRS officials until last August to find Jennifer an adoptive home in Broward, mostly because of her handicaps; her future remains uncertain because she was born "methadone addicted," according to state records.

But at least Jennifer lived. Since 1970, the deaths across the country of 68 infants or fetuses have been blamed on their mothers' use of methadone.

The deaths include 26 stillbirths, 16 miscarriages and six fatal birth defects. In addition, 20 of 95 babies who were born prematurely later died, and 14 premature infants suffered a lingering problem. Three other babies were reported as having non-fatal birth defects.

Federal Food and Drug Administration officials, who are supposed to monitor whether drugs marketed in the United States are safe and effective, were not aware of the number of infant deaths linked to methadone until the *Fort Lauderdale News* and *Sun-Sentinel* discovered them in a computer report on "adverse reactions" to methadone.

The report was prepared by the FDA's Division of Drug Experience after the newspapers asked for the information under the Freedom of Information Act. Though the division is supposed to keep track of all drugs, officials admitted that the data on adverse reactions had never before been retrieved from the computer.

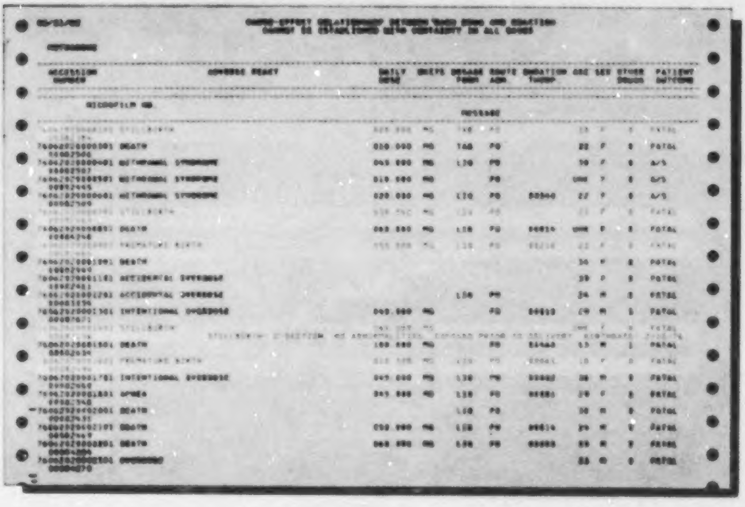
The adverse reactions reported to the agency range from fever to several cases of "heart arrest." In all, 653 reactions resulted in death — including the 68 infants.

"That does seem like an awfully high number of deaths," said Dr. Judith Jones, director of the drug experience division. She said the agency never analyzed the reports it had because "so many other things take up our resources."

By all accounts, the number of reports filed grossly underestimates true incidence. Many reports also contain obvious gaps, and errors which have escaped detection.

From January 1970 to August 1982, the FDA computer accumulated 2,177 reports of adverse reactions to methadone — only about one-third of the total reported by clinics dispensing the drug. Officials don't know what happened to reports on the rest of the cases and never tried to track them down — and they never looked at the reports they had.

The computer report also lists only one methadone-related death for all of 1979 and 1980, but clinics dispensing the drug reported 79 patient deaths related to metha-



Staff graphic by GALE [illegible]

One page from Food and Drug Administration computer printout listing adverse methadone reactions reported in June 1976 shows deaths of five babies. Printout lists type of reaction, amount taken in milligrams, whether the drug was in tablet or liquid form, how the drug was administered (PO means it was taken orally), number of days the patient had been taking methadone, age and sex of the patient, whether other drugs were involved, and the outcome (A/S stands for "alive with sequelae," meaning that the subject lived but suffered some lingering ailment). Note at top of sheet about cause-and-effect relationship is a standard FDA warning indicating that the agency did not try to verify the validity of each report.

done between Oct. 1, 1979, and Sept. 30, 1980, alone.

Division Director Jones said it is "quite possible" that most adverse reactions are not reported by clinics in the first place.

Other officials estimated that as few as 5 percent are reported. "In the real world, when an adverse reaction is suspected, we presume that most of the time we don't hear about it," said FDA pharmacist Carolyn Brophy.

The FDA is supposed to be notified of the type of reaction, amount of methadone a patient has been receiving, how long the patient had been in treatment, age, sex, other drugs involved, and what happened to the patient. But in many cases much of this information is missing or obviously wrong, the FDA report contains numerous entries in which a patient's age is given as "100," an entry officials were unable to explain.

The infant deaths also contain omissions that make it difficult to ascertain what role methadone may have played in the case.

FDA officials and other experts contacted by the *News* and *Sun-Sentinel* cautioned that no firm conclusions can be drawn from the number of infant deaths because it's unknown how many pregnant women used the drug without adverse consequences.

But Dr. Loretta P. Finnegan, associate professor of pediatrics and psychiatry at Thomas Jefferson University Medical School in Philadelphia, said the fact that 20 premature babies had died is "outrageous."

"We see these babies [born to methadone-using mothers] every day and we don't have that kind of outcome," said Ms. Finnegan, who has written many articles for medical journals on treatment of the pregnant addict.

Instead, she said, most newborns who are treated properly can be withdrawn from drugs gradually and suffer few, if any, aftereffects.

But "proper treatment" of babies born with a drug dependency involves an extended hospital stay and a complex course of administering drugs to detoxify the infant.

Nationwide, methadone clinics reported they treated 17,618 pregnant patients between 1973 and 1981. While nobody knows how many children have suffered because their mothers took methadone during pregnancy, FDA was worried from the start that the drug could endanger an unborn child.

Guidelines the agency published in June 1970, when methadone was approved as an experimental drug, warned researchers not to put pregnant women on methadone maintenance.

But FDA officials soon yielded to pressure from methadone advocates, who argued that methadone was preferable to heroin even though it was potentially dangerous. Regulations allowing pregnant women to enter methadone maintenance were published in April 1971.

That switch in signals later was represented by methadone proponents as evidence of the drug's safety.

"It is inconceivable that this FDA authorization for long-term use in pregnancy would have been included in the FDA guidelines if FDA deemed methadone maintenance unsafe," reads a 1971 report by a presidential study commission.

FDA officials never were that certain. Since December 1972, regulations have required that all female patients sign a consent form certifying they have been told that research is "inadequate to guarantee" that methadone won't "produce significant or serious side effects" in their babies.

Regulations also require that clinics reduce dosages for pregnant patients to the "lowest possible point consistent with the welfare of mother and child" and to report harmful methadone reactions to the FDA.

Government officials refused to provide a breakdown of adverse methadone reactions in Florida, arguing that release of these figures could violate confidentiality rules. The state keeps no such statistics, and adoption files such as Jennifer's are permanently sealed.

Clinics in the state treated 133 pregnant patients during 1980 and 1981, and according to FDA records only three of those women tried to rid themselves of all drugs during pregnancy. The rest apparently continued to use methadone.

Officials of the National Institute on Drug Abuse said they believe pregnant addicts should be encouraged to stop taking drugs — but they concede that goal often is impractical.

NIDA officials contend these women may be better off taking methadone under medical supervision than injecting heroin and other street drugs, which increases the risk of contracting hepatitis and other diseases.

Dr. Edward Senay, a University of Chicago psychiatrist and nationally known authority on methadone treatment, said the decision to continue treatment of pregnant women with methadone is a gamble, an issue on which there are "no experts."

A mother's use of methadone during pregnancy "is an enormous chemical assault on the fetus," Senay said. But forcing pregnant addicts to withdraw from all drugs can prove even more dangerous to an unborn child, Senay said.

"It's a cruel bind we're caught in," he said.

Uncle Sam's addicts?

Clinics fail to prove all new patients are hooked

"Patient 1028" was admitted to the St. Luke's Center for methadone treatment in June 1979 without symptoms of narcotics withdrawal. She had no needle marks on her arms, and there was no record of a urine test to confirm previous drug use.

A federal Food and Drug Administration inspector who reviewed Patient 1028's admission record in September 1979 cited the Miami clinic for enrolling the patient without obtaining evidence that she was an addict. FDA officials in Washington demanded an explanation.

St. Luke's Medical Director Joseph Albeck responded: "It remains possible that this patient may have misled admitting physicians." But the physician noted "no corrective action appears warranted" because the patient was taking a low methadone dose and trying to detoxify.

FDA officials accepted Albeck's explanation and the case of Patient 1028 was closed — even though failure to record sufficient medical evidence of addiction is considered the most dangerous violation of safety standards for methadone treatment.

"You don't give an addictive drug to someone who is not an addict," said Daniel P. Hillstrom, deputy director of the FDA's Division of Methadone Monitoring in Washington. "The whole reputation of the methadone treatment program hinges on that."

A *Fort Lauderdale News* and *Sun-Sentinel* investigation found that FDA inspectors have criticized every clinic in Florida for failing to document that all patients who received methadone actually were narcotics addicts before they were admitted to treatment.

The FDA's inspectors, who check only a random sample of patient files at each clinic they visit, reviewed 847 case files during 81 inspections of Florida clinics between 1972 and 1981. They found 98 files — 11.6 percent — that did not contain proper documentation of addiction.

"The only symptom that you can't fake is gooseflesh."
— Dr. Dale Lindberg, director of 3 clinics

"We don't say that the patient was never an addict because we can't conclude that," Hillstrom said. "That is what we suspect, but we can't find out because we were not there upon admission."

The agency claims its random file selection process constitutes a statistically valid sample whose findings "hold true for the entire population" in a clinic. The procedure is the same one used by the agency in reviewing food-processing plants and drug companies.

Projecting the inspection results to all clinics in the state during the 10 years, the *News* and *Sun-Sentinel* calculated that more than 1,000 people have been admitted to methadone treatment since 1972 without sufficient proof of addiction.

FDA officials declined to comment on the projection, though Hillstrom called the method used to calculate it "reasonable." He said his agency had "not studied undocumented admissions in a systematic way" and that such a review would not be "worthwhile."

"All the treatment people I meet are serious and want to comply with the regulations," Hillstrom said. "They abhor giving a narcotic to someone who doesn't need it."

Though no government agency ever has tried to find out for sure whether large numbers of non-addicts are able to get into methadone treatment, the FDA long has been aware of improper admissions. In December 1977, officials from FDA and the National Institute on Drug Abuse jointly sent to medical directors of the nation's methadone programs a stern memorandum reminding clinic doctors of their responsibility to ensure that all patients actually were addicts.

That memorandum was co-written by NIDA's director of professional and scientific affairs, Dr. James Cooper. Yet Cooper, in an interview, hotly denied that any non-addicts ever had been admitted into methadone programs.

While he conceded that many of the nation's programs had been cited for failing to document addiction, he insisted that these cases involved nothing more than the failure of a physician to sign his name to examination records. When asked about the Florida cases, Cooper said FDA inspectors "sometimes misinterpret" medical files.

FDA records disclose that some clinics have been cited repeatedly through the years for violating the standards. The citations peaked in 1975, when one in three records selected were cited, and have been declining since. No data are available later than December 1981 because FDA phased out its inspections.

FDA regulations require clinic doctors to establish that new patients are drug-dependent — both at the time of admission and for at least the previous year — by physical examinations, laboratory tests and other means, to weed out casual drug users looking for an inexpensive methadone "high," or people buying the drug to resell illegally.

"The mere use of a narcotic drug, even if periodic or intermittent, cannot be equated with addiction," FDA regulations state in part.

The doctor's findings must be documented in the patient's record. In most cases, however, any two indicators will satisfy an inspector.

Government documents obtained by the *News* and *Sun-Sentinel* disclose that FDA admission criteria are far more lenient than government consultants had recommended when the program was set up.

A group of Harvard Medical School doctors hired by FDA to advise the government found that their recommendations for strict admission requirements were ignored. When they obtained advance copies of FDA's proposed standards for admission in October 1972, the consultants fired off an angry letter demanding that the regulations be toughened. "There is only one criterion for physical dependence, that being signs of abstinence," they wrote.

Professional medical groups also have urged their members to adopt standards much tougher than the federal regulations. The American Psychiatric Association as early as 1971 stated that physicians should obtain "incontrovertible medical and social proof" of narcotics dependence — mainly observation of withdrawal symptoms — before admitting patients.

Doctors experienced in treating addicts with methadone note that applicants can, and sometimes do, feign symptoms of addiction in order to persuade a physician to admit them.

"The only symptom that you can't fake is gooseflesh," said Dr. Dale K. Lindberg, medical director of three South Florida clinics. Lindberg's clinics have been cited less frequently than most other programs in the state for failing to document addiction.

In the end, said Frank Nelson, director of drug abuse services for the Florida Department of Health and Rehabilitative Services in Tallahassee, it is the clinic doctor who must be on guard to avoid letting people bluff their way in.

"It is incumbent upon the clinic doctor to confirm that these people are actually addicts" before admitting them, Nelson said. "Most of these doctors are street-wise, but they still can get faked out."

States can mandate stricter controls

Even though the national methadone treatment program was set up by the federal government, state and local officials have the power to impose stricter controls on the drug's use.

According to federal Food and Drug Administration methadone regulations, one agency in each state is designated to handle matters relating to methadone. In Florida, that agency is the Department of Health and Rehabilitative Services.

The states must enforce FDA's "minimal" standards, but can enact tougher regulations. Licenses of programs failing to comply with state standards can be revoked.

HRS officials never have reviewed Florida methadone programs to determine whether stricter controls are needed.

Other parts of the country, though, have opted for a hard line. For example, Boston banned the sale of "take-home" methadone doses in the mid-1970s after reports of numerous overdose deaths associated with the drug. City officials refused to provide money for methadone programs unless clinics halted takeout sales.

More recently, New York lawmakers demanded tighter regulation of that state's programs.

Because lawmakers believed methadone "is the best treatment we have at the moment," there was little talk of ending the programs, said legislative aide Rick Spaulding.

But a 1981 evaluation by the New York Legislative Commission on Expenditure Review led to promises of corrections, particularly a crackdown on take-home sales. As a result of the evaluation, programs require a physician to review the need for take-home privileges every six months.

"They agreed to cut down on take-homes. That report got the agency to shape up," said Assemblyman Arthur J. Kremer, vice chairman of the expenditure review committee. "We didn't want to do away with the program, but we wanted it to be better run."

Thousands of teens admitted

Food and Drug Administration officials permitted methadone clinics to enroll at least 2,423 children younger than 18, even though the agency's own regulations state: "Safety and effectiveness of methadone when used in the treatment of adolescents has not been proven by adequate clinical study."

The admissions occurred between 1973 and 1976, according to FDA records obtained by the *Fort Lauderdale News* and *Sun-Sentinel*. FDA after 1976 stopped requiring clinics to report patients' ages.

The records, based on reports submitted by clinics, show that 84 methadone maintenance admissions were younger than 14, and 553 were ages 14 or 15. The remainder are listed as ages 16 or 17.

The enrollment of the 637 children younger than 16 occurred in direct violation of FDA regulations, which in December 1972 barred these minors from receiving methadone maintenance. Those same regulations permitted enrollment of clients between 16 and 18 years old provided parents gave their consent.

FDA records do not specify whether the minors enrolled between 1973 and 1976 met these criteria. Through the years, FDA officials have been liberal in granting exceptions to most agency standards.

FDA since has changed its regulations. In November 1980, the regulations were modified to permit admission of those younger than 16, so long as "prior approval" has been obtained from FDA.

Most clinic inspections result in citations

Methadone clinics in Florida have been visited by federal inspectors 81 times since 1972, two-thirds of those inspections resulted in citations for serious violations of safety standards.

Inspectors ran detailed checks on the files of 847 patients and uncovered 732 violations ranging from faulty record-keeping to failure to document that a patient was in fact addicted. Failure to document addiction is considered the most serious violation because methadone itself is an addictive narcotic.

Some samples from the inspectors' reports:

● A February 1981 inspection of Operation PAR in St. Petersburg showed that two of 13 patients reviewed were admitted "without objective evidence of current dependence on opiates." One patient had a letter from his wife claiming addiction, but no symptoms of drug dependence were recorded.

● During a 1978 inspection of the DAACO Chemotreatment Program in Tampa, program physician William W. Andrews told the FDA reviewer that he "sometimes" admitted patients based upon their stated history o[illegible]g use and his "gut feeling" about th[illegible] sincerity.

● In 1975, the staff of the Community Mental Health Center of Escambia County in Pensacola told an inspector that outreach workers or street informers were consulted to determine if a patient was a heroin user.

From 1972 through 1978, inspectors criticized the clinics heavily. In 1975, the worst year, 162 violations were found in 106 patient files reviewed.

In the mid-1970s three clinics — the St. Luke's Center and Jackson Memorial Hospital Center in Miami, and the Jacksonville Drug Abuse program — were threatened with being closed.

In 1973 and 1974, St. Luke's Center received "10-day letters," warnings that the Food and Drug Administration would revoke the clinic's license within 10 days.

The clinic at Jackson Memorial Hospital, which operated from 1969 to 1978, was cited for failure to document addiction in six of 15 files reviewed in 1974. In a letter to FDA officials in Washington four months after one inspection, program sponsor Charles Lincoln claimed the inspector had overlooked the information because the program physician's handwriting was "extremely difficult to read."

The Jacksonville Drug Abuse Program could not document addiction in 14 of 16 files reviewed during 1975, but the threat to close the program came in 1977 after an inspector found that a physician was on duty only 12 hours a week. The clinic was ordered to stop accepting new patients until operators could arrange to have a doctor spend more time there.

Each time, clinic operators promised to mend their ways, and each time FDA took no further action.

No Florida clinic ever has been closed for violating safety standards.

The clinics' records have improved significantly since 1978, when inspectors checked 106 files and uncovered 126 violations.

In 1979, inspections turned up 70 violations in 122 files; in 1980, 133 files reviewed contained 86 violations; and in 1981, 128 files revealed 64 violations — the best record in the past 10 years.

Pioneer Fla. clinic had its troubles

Florida's first methadone "clinic" was set up in Miami in March 1969 by Ben Sheppard, pediatrician, former judge, Dade County School Board president and philanthropist.

"I'd like to be remembered as a guy who tried to help people," he told an interviewer in 1971.

Sheppard, who retired as medical director of the St. Luke's Center in 1978, died last year.

How many people were helped during the nine years the affable physician spent dispensing methadone is difficult to determine.

But federal records obtained by the *Fort Lauderdale News* and *Sun-Sentinel* show that soon after Sheppard began treating drug abusers, he established a reputation for writing prescriptions for any drug a user wanted. Within three years, Sheppard's program was listed in government documents as among the "most violative" clinics in America.

Some officials urged that Sheppard's clinic be shut down, but neither the Justice Department nor federal regulatory agencies ever took decisive action despite repeated reports of violations of safety standards.

In July 1969, four agents of the Bureau of Narcotics and Dangerous Drugs (now the Drug Enforcement Administration) "enrolled in Dr. Sheppard's program and purchased 18 prescriptions for methadone." Though methadone was supposed to be given only to medically screened narcotics addicts, "at no time were any physical examinations given any of the agents," according to documents.

During the investigation, "several complaints were received [by BNDD] from parents and relatives of persons who have died of methadone overdoses due to overprescription and first-time

Ben Sheppard, an affable pediatrician well-known in Dade County, established South Florida's first methadone treatment facility. Within three years, the St. Luke's Center, where Sheppard served as medical director, was listed among the "most violative" methadone clinics in the United States.

prescriptions to non-addicts" at Sheppard's clinic, records state.

The agents recommended prosecution, but stated: "All efforts for prosecution were met with negative results because U.S. Attorney [William] Meadows [in Miami] declined to prosecute the case," according to BNDD records.

Meadows, now a Miami lawyer, said he felt the case against Sheppard was weak because it was "difficult to prove criminal intent." He recalled Sheppard as a dedicated physician with an "excellent" reputation, "who helped a lot of people with heroin problems."

Sheppard closed his facility in August 1969, largely because of pressure from federal authorities and his sponsor, the Catholic Services Bureau.

But less than a year later Sheppard reopened as a fully licensed methadone maintenance clinic, again sponsored by the Catholic Archdiocese of Miami. It was called the St. Luke's Center, at 125 SW 30th Court in Miami.

In 1972, Food and Drug Administration officials began inspecting the nation's methadone clinics to check if they were abiding by federal safety regulations. Sheppard's clinic wasn't.

In 1972 alone:

● BNDD agents found in February that the clinic's methadone was only half as potent as Sheppard stated it was. The violation is extremely serious because patients transferring to another clinic could die from an overdose.

● The FDA threatened to close the clinic within 10 days after an April inspection found numerous violations. The inspector found the clinic had no records on some patients and reported finding "four empty take-home bottles with the [patient] names scratched off" discarded on the grounds. Sheppard promised corrections; the clinic remained open.

● BNDD agents in August found six violations of standards requiring that clinics keep tight controls over methadone. Agents recommended that Sheppard's clinic be closed; no action was taken.

● An FDA inspector in September noted two recent drug-overdose deaths in which non-patients had died with a bottle of methadone dispensed by St. Luke's "in their presence." Quoting from clinic records, the inspector noted that "two St. Luke's patients no longer in the program were suspected of these diversions."

A BNDD document dated Jan. 30, 1973, ranked the St. Luke's Center eighth "in order of significance" on a list of 13 clinics nationwide rated "beyond assistance either due to attitude, criminal intent or profit motivation."

Others on the list included a doctor in the Bronx who made $3,000 a day dispensing methadone through a slot in his office door to anyone with the money, a Tucson, Ariz., physician who allegedly prescribed methadone in "any amount according to the patient's ability to pay" and whose dispensing practices were "the cause of 11 overdose deaths," and a New Mexico program whose director was arrested on charges of selling heroin and suspected of using federal money to buy heroin in Mexico.

Between 1973 and 1978, FDA officials twice threatened to close the St. Luke's Center, but repeated warnings failed to halt what officials called "objectionable" practices — ranging from failure to document that all patients were addicts to allowing too many take-home doses.

"We have problems deciding whether to close a program down if it is improving," said Daniel P. Hillstrom, deputy director of the FDA Division of Methadone Monitoring. "These programs are an aid to the community. Maybe some of them should be closed, but that is a drastic action."

Monsignor Bryan Walsh, executive director of the Catholic Services Bureau since 1975, said most of the center's problems with government regulators stemmed from sloppy record-keeping, a situation he insisted has been corrected.

"Dr. Sheppard had a great disdain for bureaucrats. He despised them," Walsh said. "He just felt that record-keeping was an unnecessary evil."

Walsh said the center corrected all deficiencies after Sheppard's retirement in September 1978; currently, he said, the program is "very good."

The first three federal inspections of the clinic after Sheppard's retirement resulted in more findings of "significant deviations" from FDA standards, records show. However, the most recent review, completed in April 1981, indicated the clinic was substantially in compliance with the regulations.

Urine tests ignored, all but abandoned

Urine tests, which can reveal whether a patient has been using heroin or other unauthorized drugs while receiving methadone, have been all but abandoned by federal officials.

The first goal of methadone treatment is to halt heroin use, so these tests can signal if the therapy is not working. The tests also can warn if a patient is abusing more than one drug, which can be fatal.

"Obviously, one of the goals of urine testing is to prevent the patient from hurting himself," said Richard Harrington, director of the Comprehensive Drug Abuse Program for Dade County, which operates two methadone clinics.

But urine tests are an expense and occasionally an embarrassment to clinics. Some clinics have found that nearly half their patients continued to use heroin while receiving methadone.

Based on government records, the *Fort Lauderdale News and Sun-Sentinel* calculated that from 1974 through 1976, 27.7 percent of samples tested nationwide showed the presence of heroin along with methadone.

The record of Florida clinics overall was about the same — 28 percent of the tests showed that patients continued to use other opiates while receiving methadone. In 1975, however, 40 percent or more of the patients at three clinics tested positive for unauthorized drug use: the Broward Methadone Maintenance Rehabilitation and Research Facility in Hollywood, 41 percent; Operation PAR in St. Petersburg, 40 percent; and the Methadone Treatment Center in Jacksonville, 55 percent.

The U.S. Food and Drug Administration collected the urine test reports from the clinics, but no one had ever analyzed the numbers to see how well methadone treatment was working.

In 1976, the federal government stopped collecting information from clinics on test results, and in 1980 government officials drastically reduced the frequency of required tests from once a week to eight times a year.

Harrington's publicly funded programs test the urine of most patients once a month despite the eased regulations, he said.

Because test data no longer are collected, federal officials have no way to determine the effect of relaxing the test requirements. But statistics collected by New York state, which treats about 40 percent of the nation's methadone patients, show that combined drug abuse by patients remains a problem.

Urine test results demonstrate that one of the major arguments used to sell the methadone maintenance theory was not entirely accurate.

New York physician Vincent Dole helped win support for his concept of methadone maintenance in the late 1960s when he claimed methadone set up a pharmacological block against heroin use. Once a patient was stabilized on methadone, he no longer would crave heroin, Dole said.

In a recent interview, Dole conceded that many methadone patients abuse heroin and other drugs while in treatment. But he insisted that the incidence is highest in programs that place patients on low doses — 40 milligrams a day or less — for fear of overmedicating them.

"Most of the programs that are running low doses on ideological grounds have poor records," said Dole, senior physician at Rockefeller University in Manhattan, a research institution.

Dole offered no evidence to substantiate that assertion.

New York City methadone programs — which are considered relatively high-dose programs — have reported a dramatic increase since 1978 in the number of tients abusing heroin while in the progr

In 1978, the New York City progr reported that 13.4 percent of their patie tested positive for heroin. The figu reached 23 percent in 1981; state officials claimed that an influx of "high-quality" heroin was "tempting otherwise successful patients."

Dole concedes that methadone does not steer patients away from using tranquilizers, which combine with methadone to cause many overdose deaths. Curbing abuse of tranquilizers, he said, requires "diligent, compassionate and vigilant care."

FLORIDA'S METHADONE PROBLEM

'Cure' most deadly drug in Broward

Paramedics found George Blumberg's body sprawled on the sofa in his Fort Lauderdale apartment, bloody foam thickening around his nose and mouth and a half-empty bottle of methadone nearby.

Methadone, a synthetic narcotic once touted as a savior for addicts of heroin or other opiates, didn't help curb Blumberg's craving for other drugs.

It helped kill him.

Blumberg was one of 29 residents of Dade and Broward counties whose deaths in 1980 and 1981 from accidental drug overdose were blamed at least in part on methadone. In the same two years heroin and other narcotics — the drugs methadone is intended to combat — were linked to only 13 deaths.

By contrast New York City, America's heroin and methadone capital, consistently has reported heroin-related deaths to be three times to four times more frequent than those linked to methadone.

"This is outrageous and stupid in a community like ours," Dr. Ronald Wright, Broward's chief medical examiner, said when told of the *Fort Lauderdale News* and *Sun-Sentinel's* findings. "We don't have a heroin problem, we have a methadone problem."

South Florida's methadone death toll is "unique," said Joseph Murphy, who measures drug abuse deaths for the Drug Enforcement Administration in Washington.

"There is an inordinate amount of deaths related to methadone [in South Florida] compared to heroin. It should be a guide to further investigation," Murphy said.

Some of the dead got their fatal doses of methadone illegally, through a thriving black market fueled by lax controls on the drug's distribution; others, like Blumberg, got it at one of the nine clinics in South Florida.

U.S. Food and Drug Administration documents show that deaths of methadone-clinic patients have soared in Florida in recent years.

Methadone: The facts

- ● Methadone was at least a partial cause of 29 drug overdose deaths in South Florida during 1980 and 1981 — twice as many deaths as attributed to heroin and other narcotics.
- ● That death toll includes 15 methadone clinic patients — 10 percent of reported fatalities nationwide during those two years. Only 2 percent of methadone patients nationwide are enrolled in Florida clinics.
- ● During the past 10 years methadone, alone or mixed with other drugs, has been responsible for the deaths of at least 4,417 people nationwide.
- ● The federal agencies that sanctioned the drug's use have collected masses of information about the methadone program but never analyzed the data.

Two methadone-related patient deaths were reported in 1978, three in 1979; the reported toll jumped to eight in 1980, and the *News* and *Sun-Sentinel* learned of a ninth patient death in Miami during 1980 that was not reported to the government.

The eight reported 1980 Florida deaths constitute 10.1 percent of the nationwide total of 79 that year — even though Florida clinics treated only about 2.1 percent of the country's methadone patients.

In 1981, the Florida clinics reported seven patient deaths, 8 percent of the nationwide total of 86; that year, the clinics treated about 2.5 percent of the patients nationwide.

All but one of the patient deaths during the two years occurred in South Florida.

Florida's upsurge in methadone patient deaths was called "incredible" by Dr. James Cooper, director of the Division of Medical and Professional Affairs for the National Institute on Drug Abuse (NIDA), which oversees the methadone program alongside FDA.

"That is something that should be looked at," Cooper said.

Officials of the FDA's Division of Methadone Monitoring, which is responsible for regulating treatment centers, said they were unaware of the increase in patient deaths, even though the division had in its files reports from the clinics listing the deaths.

"We don't have the staff to evaluate these documents," said Daniel P. Hillstrom, deputy director of the methadone monitoring division.

Cooper and other government officials insist that methadone is a "lifesaving" treatment for addicts — even though some patients die in therapy.

"There are casualties in every type of [medical] treatment," Cooper said. "It's terrible on the [patient's] family but the cost is relative. We know we have people who are not cured [by methadone]. We never thought we would cure everybody."

George Blumberg was one patient who was not cured.

On Feb. 28, 1981, a Saturday, Blumberg drove to the Pompano Methadone Treatment Center in Pompano Beach for his daily methadone. He also paid $5 for a second bottle of the liquid, which he was supposed to take at home on Sunday, when the clinic was closed.

Methadone is supposed to eliminate an addict's craving for narcotic drugs, but often it does not. And if methadone is combined with non-narcotic drugs — the abuser's method of choice — even small doses can lead to death.

Blumberg bought three pills of dilaudid, another potent narcotic sometimes dissolved and injected by addicts unable to procure heroin, at a bar west of Fort Lauderdale several hours after he left the clinic, according to Fort Lauderdale police records.

“This is outrageous and stupid in a community like ours. We don’t have a heroin problem, we have a methadone problem.” — Dr. Ronald Wright, Broward County medical examiner

He took the pills at home and apparently drank some of his Sunday methadone a day early.

Blumberg’s girlfriend, who went with him to the bar, called paramedics just before 10 p.m. when she couldn’t wake him.

The rescue workers found Blumberg dead. Blood and foam were clotting over his nose and mouth, a sign that a drug overdose had caused his lungs to fill with fluid.

A half-empty methadone bottle bearing Blumberg’s name was the only evidence of drugs found at the scene; tests showed methadone, dilaudid and diazepam, a sedative sold under the trade name Valium, in his body.

Medical Examiner Wright ruled that “methadone and dilaudid intoxication” killed Blumberg, who at 32 had a string of arrests for illegal possession of drugs and for other offenses dating to 1969.

A precise measure of methadone’s prominence in Florida drug-overdose deaths through the years is virtually impossible to establish because of wide gaps in record-keeping.

To spare family members embarrassment, most police agencies traditionally have declined to publicize drug overdose deaths, and few medical examiners catalogue these deaths separately.

In Palm Beach County and in Jacksonville, where methadone clinics also operate, record-keeping procedures have been so lax that officials cannot spot drug abuse trends. The Palm Beach County medical examiner recently resigned under fire from state officials, who found his records in disorder. Medical examiners in Tampa, St. Petersburg and Pensacola, where methadone clinics operate, said methadone-related deaths in their jurisdictions are rare.

Many Broward County records before 1980 either cannot be located or are so sketchy that they are of little value in compiling statistics. When Wright took over as Broward’s chief medical examiner in 1980, he modernized the record-keeping system.

The Dade County Medical Examiner’s Office is the only one in Florida that since 1974 has reported drug overdose deaths to the DEA’s tracking system, the Drug Abuse Warning Network (DAWN).

The FDA, which relies on clinics to report deaths and other patient reactions caused by methadone, never has collected statistics on methadone-related deaths of nonpatients.

FDA officials concede they have lost the clinics’ reports from Florida programs for at least the years 1976 and 1977, and at least one death in 1980 never was reported to the agency.

The deaths of clinic patients make up only about half the deaths associated with abuse of methadone.

The rest apparently obtained methadone from friends enrolled in the programs or bought the narcotic illegally through a largely overlooked black market.

“Methadone is available on the streets,” said Clyde McCoy, a psychologist at the University of Miami who has studied drug abuse trends. “Some [drug abusers] prefer it to street drugs because they are usually assured of its quality and consistency.”

Drugs found in Reyburn Roulston Jr.'s apartment included prescribed methadone, in foreground.

Drug orgy cost man his life

Reyburn Roulston Jr., formerly a federal auditor, was a classic example of a methadone patient who died from a smorgasbord of drugs.

Roulston, 32, had been a patient at the Broward Methadone Maintenance Rehabilitation and Research Facility in Hollywood. But during the week of Oct. 20, 1981, he engaged in a fatal drug orgy by mixing methadone he received from the clinic and pills he obtained elsewhere.

When his father found him lying on the kitchen floor of his Hollywood apartment, Roulston had been dead for several days. Cause of death was ruled accidental "combined drug poisoning," based on toxicology tests showing methadone, an unspecified antidepressant drug and a small amount of alcohol in his body.

The evidence room at the county morgue still holds the 42 bottles of legally prescribed medicines, including one full bottle of methadone and six empties, found in Roulston's apartment. A handful of pills was found in the dead man's pants pocket.

The prescription bottles bear a variety of names, suggesting that Roulston was seeing several doctors under assumed names or had traded pills with his friends.

In any case, Roulston stockpiled a vast array of addictive and commonly abused drugs while attending the methadone program. His pills included medications intended to relieve depression, to induce sleep, to help in weight loss and to ease pain.

Dilaudid: The Florida habit

On the streets of South Florida, where heroin often is scarce, narcotics abusers go looking for "D's."

Dilaudid, an addictive painkilling pill which can be crushed, dissolved and injected, sells for as much as $50 a pill on the street.

Nationwide, four of every five narcotics addicts admitted to treatment are hooked on heroin. In Florida, where drug traffickers concentrate on cocaine, methaqualone and marijuana from South America rather than on heroin, just more than half the patients are heroin addicts; most of the rest, particularly in South Florida, are dependent on dilaudid.

"I would say that eight of 10 admissions into methadone treatment are for abuse of dilaudids," said Shirley Stone, a consultant to drug abuse treatment programs and former nursing director at the Broward Methadone Maintenance Research and Rehabilitation Facility in Hollywood.

Dilaudid sometimes is stolen from pharmacies, but the vast majority is dispensed legally, often by a small number of area physicians who prescribe the drug either out of ignorance or for profit.

Drug Enforcement Administration figures show Florida ranked third in the nation in legal dilaudid sales during 1981, a slight decrease from previous years. Nearly 7 million milligrams of the drug was dispensed legally. In the same period no more than 135,000 milligrams was reported stolen statewide, mostly from night break-ins at pharmacies.

"We have advised our members to be more judicious in writing prescriptions for dilaudid," said Dr. Robert Johnson, director of the Florida Medical Association's Committee on Drug Abuse. "It is obvious that the drug has not been used [by patients] in the way doctors feel it has been used."

State licensing authorities also say they are getting tough on the handful of doctors responsible for placing enormous quantities of dilaudid on the streets.

In early June, the Florida Board of Medical Examiners revoked the license of Dr. Jose A. Torres, a Pompano Beach general practitioner charged with writing hundreds of dilaudid prescriptions that were not "medically justified" for known drug abusers. One patient was prescribed 825 of the pills during a two-month period in 1981.

In another case, Dr. Elias Matos, of Miami, surrendered his medical license last September after state officials charged him with improperly prescribing more than 12,000 dilaudid tablets during six months in 1980.

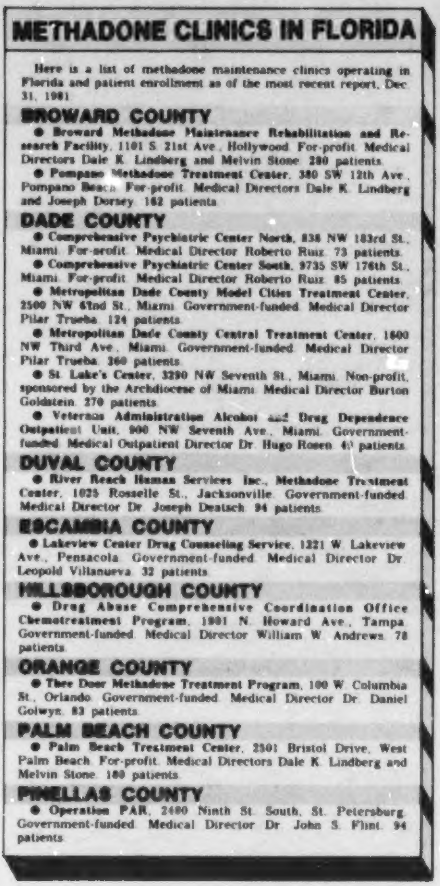
"We consider [cracking down on improper prescribing] an important part of our regulatory authority," said Diana Hull of the state Department of Professional Regulation.

THE DRUGS OF DEATH

	1980	1981
Methadone	**5**	**7**
Heroin	0	1
Morphine	**0**	**1**
Dilaudid (painkiller)	1	1
Diazepam (Valium)	**2**	**2**
Methaqualone (Quaaludes)	5	7
Cocaine	**5**	**7**
Barbiturates (sedatives)	1	5
Darvon (painkiller)	**1**	**1**
Mellaril (anti-depressant)	1	0
Dilantin (seizure control)	**1**	**0**
Benzodiazepene (anti-anxiety)	0	3
Phencyclidine (PCP)	**0**	**1**
Amitriptyline (anti-depressant)	0	1

SOURCE: Toxicology reports, Broward County Medical Examiner's Office.

Chart shows the number of times each drug was found in the bodies of victims of accidental overdoses during 1980 and 1981 in Broward County. Most of the 11 deaths in 1980 and the 22 in 1981 involved several drugs.



METHADONE CLINICS IN FLORIDA

Here is a list of methadone maintenance clinics operating in Florida and patient enrollment as of the most recent report, Dec. 31, 1981.

BROWARD COUNTY

- **Broward Methadone Maintenance Rehabilitation and Research Facility**, 1101 S. 21st Ave., Hollywood. For-profit. Medical Directors Dale K. Lindberg and Melvin Stone. 280 patients.
- **Pompano Methadone Treatment Center**, 380 SW 12th Ave., Pompano Beach. For-profit. Medical Directors Dale K. Lindberg and Joseph Dorsey. 162 patients.

DADE COUNTY

- **Comprehensive Psychiatric Center North**, 838 NW 183rd St., Miami. For-profit. Medical Director Roberto Ruiz. 73 patients.
- **Comprehensive Psychiatric Center South**, 9735 SW 176th St., Miami. For-profit. Medical Director Roberto Ruiz. 85 patients.
- **Metropolitan Dade County Model Cities Treatment Center**, 2500 NW 62nd St., Miami. Government-funded. Medical Director Pilar Trueba. 124 patients.
- **Metropolitan Dade County Central Treatment Center**, 1600 NW Third Ave., Miami. Government-funded. Medical Director Pilar Trueba. 260 patients.
- **St. Luke's Center**, 3290 NW Seventh St., Miami. Non-profit, sponsored by the Archdiocese of Miami. Medical Director Burton Goldstein. 270 patients.
- **Veterans Administration Alcohol and Drug Dependence Outpatient Unit**, 900 NW Seventh Ave., Miami. Government-funded. Medical Outpatient Director Dr. Hugo Rosen. 40 patients.

DUVAL COUNTY

- **River Reach Human Services Inc., Methadone Treatment Center**, 1025 Rosselle St., Jacksonville. Government-funded. Medical Director Dr. Joseph Deatsch. 94 patients.

ESCAMBIA COUNTY

- **Lakeview Center Drug Counseling Service**, 1221 W. Lakeview Ave., Pensacola. Government-funded. Medical Director Dr. Leopold Villanueva. 32 patients.

HILLSBOROUGH COUNTY

- **Drug Abuse Comprehensive Coordination Office Chemotreatment Program**, 1801 N. Howard Ave., Tampa. Government-funded. Medical Director William W. Andrews. 78 patients.

ORANGE COUNTY

- **Thee Door Methadone Treatment Program**, 100 W. Columbia St., Orlando. Government-funded. Medical Director Dr. Daniel Golwyn. 83 patients.

PALM BEACH COUNTY

- **Palm Beach Treatment Center**, 2501 Bristol Drive, West Palm Beach. For-profit. Medical Directors Dale K. Lindberg and Melvin Stone. 180 patients.

PINELLAS COUNTY

- **Operation PAR**, 2400 Ninth St. South, St. Petersburg. Government-funded. Medical Director Dr. John S. Flint. 94 patients.

“It may have been the case that a death was not followed up. Sometimes we don't know why patients don't come to the clinic any longer.”

— Richard Harrington,
Dade County methadone administrator

Dade patient’s death unreported

Jorge Fernandez was seen banging his head against telephone poles shortly after he left a counseling session at the Model Cities Treatment Center in Miami, where he received methadone treatments.

Fernandez, 27, died that day, April 30, 1980, of multiple drug intoxication, according to Dade County Medical Examiner's Office and Miami Beach police records. Clinic officials apparently never bothered to find out what happened to the Hialeah resident when he didn't return for treatment.

Methadone treatment clinics are supposed to report any patient's death to the Food and Drug Administration within two weeks, but Fernandez's death never was reported. His death is not counted among the 79 fatalities in 1980 attributed at least in part to methadone.

Richard Harrington, the administrator who oversees Dade County's methadone programs, declined to comment on Fernandez's death, citing patient confidentiality. But he conceded that FDA officials recently criticized another Dade methadone clinic under his supervision for failing to find out what happens to patients who suddenly disappear from treatment.

“It may have been the case that a death was not followed up,” he said. “Sometimes we don't know why patients don't come to the clinic any longer.”

FDA officials concede that generally they have no way of knowing whether methadone clinics are accurately reporting deaths and other adverse reactions to methadone.

Heroin again on the upswing

For reasons nobody can readily explain, heroin comes and goes.

In the late 1960s, fear of a heroin “epidemic” wracked the nation and led to the creation of the national methadone program.

But by the mid-1970s, heroin became harder to get, and drug dealers diluted what they sold to keep their profits up. Government statistics reflect a steady decrease in deaths and hospital emergency-room visits linked to heroin, both in South Florida and nationwide, through the late 1970s.

But in the early 1980s, heroin-related injuries began increasing again, particularly in Northeastern cities. Officials believe the new flow of heroin comes from Iran, Afghanistan and Pakistan.

Some government officials believe intensified international drug-enforcement efforts account for the periodic declines; others say lessening demand is the reason.

But no one knows for sure.

Private clinics are booming, earn millions

On the east side of the railroad tracks along Dixie Highway in Hollywood, the methadone business is booming — quietly.

"We don't even have a sign on our door," said Dr. Dale K. Lindberg, medical director of the Broward Methadone Maintenance Rehabilitation and Research Facility. "Our clients aren't proud of coming here."

Proud or not, hundreds of drug abusers flock to the unmarked storefront — and to Lindberg's affiliated clinics in Pompano Beach and West Palm Beach — to buy $5 daily doses of methadone.

The three privately owned clinics — the only sources of methadone therapy in the two counties — grossed $1,096,000 in 1979, the only year the clinics reported finances to the National Institute on Drug Abuse.

The Hollywood clinic, operated by general practitioner Lindberg and cardiologist Dr. Melvin Stone, reported gross receipts from client fees of $506,000; the Pompano Methadone Treatment Center, run by Lindberg and Dr. Joseph Dorsey, reported $350,000; and the Palm Beach Treatment Center, directed by Lindberg and Stone, reported $240,000.

Nationwide, most methadone clinics are supported by tax dollars; tax-supported clinics are paid about $1,700 per patient per year by the federal government.

In South Florida, privately owned profit-making clinics — Lindberg's three, plus two in Dade County operated by psychiatrist Roberto Ruiz — are predominant. These clinics receive no government money, making their money from client fees.

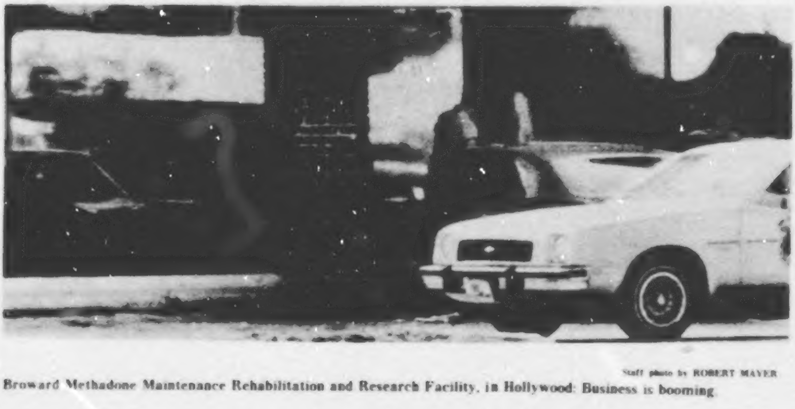
Neither Lindberg nor his associates would discuss their operations.

The only year Lindberg's clinics reported their finances was 1979, and they were not required to even then. But presumably the clinics are making more money now. On Dec. 31, 1981, the three private clinics reported 622 patients in treatment; that's a 29 percent increase over 1979 and about one-third of all methadone patients in the state.

In September 1980, for-profit clinics treated 20 percent of Florida's methadone patients, the highest percentage in the nation at that time. By December 1981, for-profit clinics were treating twice that proportion of patients — more than 40 percent of all patients in the state, according to federal government figures. No national figures are available for 1981.

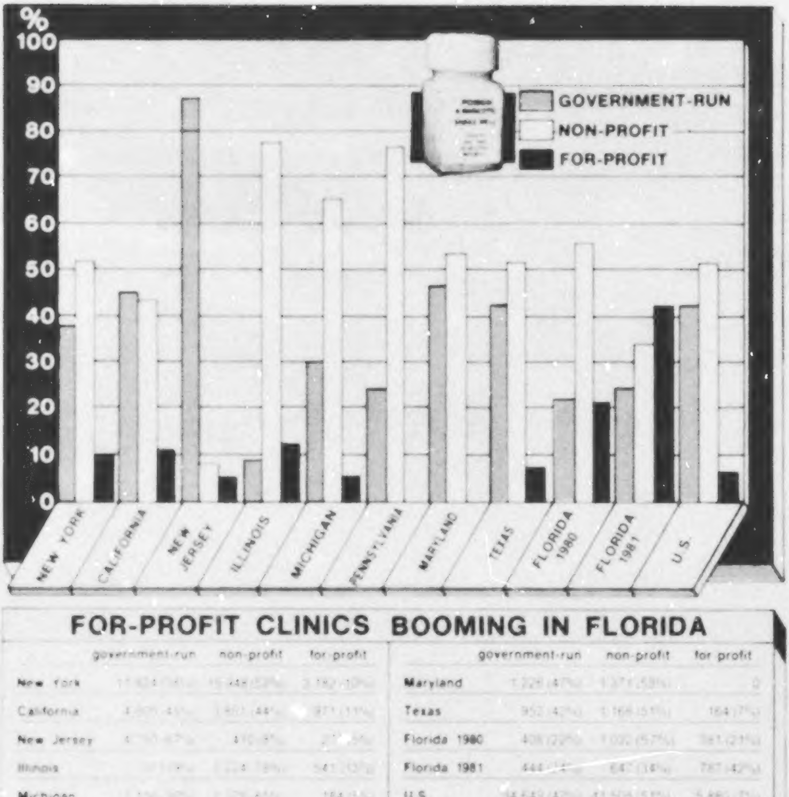
"The future of methadone treatment in Florida is definitely for-profit," said Frank Nelson, director of drug abuse programs for the state Department of Health and Rehabilitative Services. Nelson said he expects federal and state budget cuts will spur this growth.

But in a climate of lessening government



Staff photo by ROBERT MAYER

Broward Methadone Maintenance Rehabilitation and Research Facility, in Hollywood: Business is booming.



FOR-PROFIT CLINICS BOOMING IN FLORIDA

	government-run	non-profit	for-profit
New York	11,424 (38%)	15,448 (52%)	3,182 (10%)
California	4,805 (45%)	4,807 (44%)	1,171 (11%)
New Jersey	4,150 (87%)	410 (8%)	[illegible] (5%)
Illinois	[illegible] (9%)	3,224 (78%)	541 (13%)
Michigan	1,156 (30%)	2,529 (65%)	184 (5%)
Pennsylvania	741 (23%)	2,501 (77%)	0
Maryland	1,226 (47%)	1,371 (53%)	0
Texas	952 (42%)	1,168 (51%)	164 (7%)
Florida 1980	408 (22%)	1,020 (57%)	381 (21%)
Florida 1981	444 (24%)	647 (34%)	787 (42%)
U.S.	34,649 (42%)	41,505 (51%)	5,880 (7%)

SOURCE: National Institute on Drug Abuse, National Drug and Alcoholism Treatment Utilization Survey

Staff graphic by GALE ENGELKE

Chart shows number of patients enrolled in each type of clinic and percentage of state total in the largest methadone-dispensing states. For-profit clinics treat a higher percentage of methadone patients in Florida than in the rest of the country, according to the most recent available national report, dated Sept. 30, 1980. By the end of 1981, the percentage of Florida patients enrolled in for-profit programs had doubled.

regulation, some critics question whether clinics which dispense a potent narcotic for profit are sound public policy, even though they save taxpayers money.

"I'm absolutely opposed to any more for-profit programs in Florida," said Shirley Colletti, executive director of Operation Par, a government-funded methadone clinic in St. Petersburg.

Mrs. Colletti said the presence of profit-making programs tends to encourage patients to "shop around" for the clinic that will give them the best deal — the highest doses, the most lenient take-home privileges. Fear of losing clients to a competitor also may render clinic officials "afraid to offend" their patients by imposing restrictions on them, she said.

"For-profit methadone programs could become like a gas war. There is tremendous potential for abuse," she said.

The *News* and *Sun-Sentinel* used government documents to establish that the five for-profit clinics in South Florida are far more lenient in dispensing methadone than their government-funded counterparts.

The for-profit centers dispense the highest average daily dosages in the state — 85 percent of their patients receive more than 40 milligrams daily — and grant take-home privileges to almost every patient.

Food and Drug Administration regulations give all methadone clinics considerable leeway in determining dispensing policies. Yet overall, federal regulators have less authority to discipline for-profit programs than their publicly funded counterparts.

Publicly, federal officials have stayed out of the debate about for-profit programs. But FDA records show that in the past, agency officials have stated that for-profit methadone clinics in South Florida could cause problems.

Late in 1977, Lindberg and another Broward doctor and their staffs were selling methadone to drug abusers at separate clinics in Pompano Beach.

"There is intense competition," wrote an FDA inspector investigating allegations that one for-profit clinic improperly had tried to lure another's patients and staff.

The inspector found no basis to the claims, but did report that "animosity" from the rivalry could have an "adverse effect on patient care."

The dispute was settled when Lindberg and the other doctor, Bernard Milloff, merged their clinics into what is now the Pompano Methadone Treatment Center.

Lindberg has been in the methadone business since 1970, when he opened a storefront clinic in Dania with his wife Rhoda, Stone and Stone's wife Shirley, an energetic registered nurse and drug-abuse treatment crusader.

The center moved to Hollywood after Dania officials denied it an occupational license.

Today, Shirley Stone and Lindberg are considered experts in methadone maintenance, at least in Florida. Mrs. Stone operates a consulting business for drug-abuse treatment programs elsewhere in the state.

Few Florida critics quibble with this experience; nor have they gathered evidence suggesting that for-profit programs stress financial concerns over the welfare of their patients. But the concept of methadone sales for profit worries them nonetheless, mostly because of a steady relaxing of government regulation.

"We're not opposed to free enterprise," said Dr. Robert Johnson, a Tallahassee general-practice physician who heads the drug-abuse committee of the Florida Medical Association. "But there should be significant controls over these clinics."

“Sometimes figuring out which drug killed these people is like trying to figure out which injury killed a man who fell from an airplane.”
— Dr. Charles Wetli,
Dade deputy chief
medical examiner

Quest for a better ‘high’ turns medicine to poison

Paramedics found Biagio “Bennie” Sacco Jr. stumbling along Hallandale Beach Boulevard in a drug-induced stupor, shouting that he was “in heaven.”

He was semi-conscious, incoherent and barely breathing when paramedics rushed him to Memorial Hospital in Hollywood early on the morning of May 24, 1980. Two hours later, he died in the hospital’s emergency room. A medical examiner’s report said the cause of death was “self-ingested combined overdose of drugs.”

Sacco, 31, a machinist with a 15-year history of drug abuse, had been under a doctor’s care and was receiving daily methadone treatments at St. Luke’s Center in Miami, according to Broward County Medical Examiner’s Office records.

The methadone that was supposed to curb his drug abuse helped kill Sacco. He had mixed it with methaqualone and diazepam, a sedative marketed under the trade name Valium.

Most drug abuse deaths are due to a combination of drugs. Reviewing drug overdose deaths in South Florida, the *Fort Lauderdale News* and *Sun-Sentinel* found that mixing methadone with diazepam, which extends the narcotic’s euphoria, killed at least 10 people during 1980 and 1981.

“There is an indication that we have a problem here, a new look in drug abuse,” said Dr. Charles Wetli, Dade County’s deputy chief medical examiner. Wetli said he was “surprised” to hear of the *News* and *Sun-Sentinel* findings.

Chronic drug abusers often take enormous quantities of a single drug without harm, but mixtures can prove fatal.

“Sometimes two plus two equals six,” said Wetli, whose studies of drug abuse deaths have been published in leading medical journals.

Even when extensive and expensive laboratory tests are performed, one drug rarely can be considered the cause of death when others are present. Thus, medical examiners in most cases rule the cause of death “combined drug poisoning” or “multiple drug intoxication,” rulings which implicate all drugs present in the body as contributing to death.

“Sometimes figuring out which drug killed these people is like trying to figure out which injury killed a man who fell from an airplane,” Wetli said.

Methadone helped kill one addict in hospital

Steven Ferber was "shaking and salivating" from narcotics withdrawal the day he agreed to enter P.L. Dodge Memorial Hospital in Miami.

His goal was to kick a longstanding heroin habit in a program known as "detox" — short for detoxification, a hospital regimen that was supposed to leave him free of drugs at the end of 21 days.

He received methadone to help wean him from heroin.

But two days later, on July 24, 1979, Ferber died in the psychiatric hospital from an accidental overdose of methadone and diazepam, a tranquilizer sold under the trade name Valium, according to Dade County Medical Examiner's Office records.

Just how the methadone "cure" proved fatal remains unclear.

However, hospital records indicate that Ferber was injected with far more than the amount of methadone recommended for detoxification.

U.S. Food and Drug Administration regulations recommend that a heroin addict entering a detox program initially be given 15 to 20 milligrams of methadone a day. The dosage is to be steadily decreased during three weeks.

The patient is supposed to be watched by a physician to make sure the dose is large enough to prevent withdrawal symptoms.

Ferber initially got 30 milligrams of methadone, according to hospital records. In two days at the facility he received injections totaling between 90 and 120 milligrams, the exact amount was not specified in the autopsy report.

Steven Ferber wanted to kick his longstanding addiction to heroin. But prescribed methadone, mixed with a tranquilizer, proved fatal.

P.L. Dodge Medical Director Dr. Marvin Isaacson had doubted Ferber's sincerity in wanting to detoxify, but admitted him anyway.

"It was my impression at the time that he was more interested in a fix than in detoxification," Isaacson, a psychiatrist, wrote in his notes. "He was full of rationalizations, very manipulative and his story was full of inconsistencies."

Ferber had told quite a story, though there is no evidence in the file that the patient's claims were verified before treatment began.

He told the doctor that he had been "shooting" heroin for 10 years, and that he had been kicked out of several drug treatment programs, including three in Miami and one in St. Petersburg.

He claimed to have failed several detox efforts as well.

As early as 1975, the National Institute on Drug Abuse distributed a memorandum warning methadone-program operators that there was "no evidence" inpatient detox was any more effective than outpatient, though inpatient was "considerably more expensive." The memo stated that inpatient detox should be "seriously questioned in most circumstances." Exceptions were noted for severely psychotic patients or those also addicted to barbiturates, but there is no evidence in Ferber's treatment plan that he met either criterion.

Ferber startled Dodge hospital staff with his extensive knowledge of narcotics, both the pharmaceutical and the street variety.

He claimed to be "depressed" by the methadone he was receiving and begged Isaacson to switch him to dilaudid, a legal drug often abused by addicts in South Florida.

"He obviously liked the effects of the latter," Isaacson wrote in the patient's medical chart. The request was refused.

Ferber settled for methadone. Records show it was administered by injection at least three times during the two days.

Where he got the diazepam found in his body remains a mystery.

Ferber's medical record contains no indication of the source, and medical examiner's documents indicate that the question was not investigated.

Ferber's records do show that he died in bed alone, apparently without trying to summon nurses.

At 6 p.m. he refused an early dinner and went to sleep, according to the nurses' notes. At 10 p.m. he was said to be sleeping soundly, but could be awakened. At 7 a.m. he was found to be "not breathing."

"I was called by the charge nurse of the floor and advised that the patient was apparently deceased," Isaacson wrote. "Pupils were fixed, he did not respond and there were no vital signs. The patient was obviously deceased."

DEATH ON THE STREETS

Methadone sold widely on streets

Methadone, the government-subsidized drug that was supposed to end heroin addiction, has killed or sickened thousands of people who never should have been able to get their hands on it.

Thousands more have become addicted to illegal methadone, then sought help at government-funded clinics; their treatment has cost taxpayers an estimated $15 million.

Some "street methadone" is stolen from pharmacies and the nation's methadone clinics, but most of it is sold, traded or given away by clinic patients who get strong doses of the drug to take at home, away from medical supervision.

"An illegal market for methadone exists in every city in the country," said Dr. Arnold Washton, director of the Division of Drug Abuse Research and Treatment at New York Medical College.

A *Fort Lauderdale News* and *Sun-Sentinel* investigation of the nation's methadone program revealed:

- Obscure data from a five-year federally financed study, *Student Drug Use In America*, indicates that more high-school seniors have experimented with illegal methadone than with heroin.
- Medical examiners in 26 major cities reported that of the more than 4,403 people whose deaths between 1974 and 1981 were attributed at least in part to methadone, fully half were not in a treatment program, but had used the liquid form of the drug. Liquid methadone is dispensed only by government-licensed clinics, generally mixed with orange juice so abusers won't inject it into their veins; therefore, any non-patient who died from liquid methadone probably obtained the drug from a clinic patient illegally. The form of methadone involved in more than 1,300 other deaths was not reported.
- Big-city hospitals reported that only half of the 22,300 people treated in emergency rooms for methadone-related ailments got their methadone through a treatment program prescription. That means more than 11,000 people were sickened by street methadone from 1974 to 1981.
- The hospitals also reported that more than 2,500 methadone-related cases were clinic patients who said they were sickened by street methadone they bought to increase the "kick" of their clinic-supplied dose.
- Government-funded drug treatment programs nationwide reported that from 1973 through 1981, 23,046 persons were admitted to treatment because they were addicted to illegal methadone. Their treatment has cost taxpayers as much as $15 million.
- In Florida from January 1981 through March 1982, 104 people admitted to drug treatment programs said they had become addicted to methadone obtained illegally, according to statistics reported to the state Department of Health and Rehabilitative Services.

"I don't doubt that methadone has created some addicts," said Dr. Edward Tocus, a pharmacologist with the U.S. Food and Drug Administration's Division of Drug Abuse. "Spreading addiction bothered us initially. That was one reason that we put tight controls on methadone. I don't doubt that our efforts have not been 100 percent effective."

Just how ineffective those controls have been is demonstrated by the study *Student Drug Use In America*, which indicated that, during the past five years, more high-school seniors had sampled methadone than had tried heroin.

Tocus was shocked by the survey. "These findings are new to me. That is absolutely devastating, very worrisome," he said.

The study has been compiled annually since 1975 by the Institute for Social Research at the University of Michigan, under contract from the National Institute on Drug Abuse. Researcher Patrick O'Malley, who helped put the study together, said it is an accurate reflection of national drug abuse patterns among the estimated 3.2 million high-school seniors.

Extension of the study's findings to all high-school seniors indicates that 132,800 sampled illegal methadone and only 92,800 used heroin.

If anything, O'Malley said, the study underestimates the prevalence of narcotics use "because the kids that are very heavy into drugs are not likely to be in school."

The extent of heroin use is pub-

Methadone: The facts

- Illegal methadone, much of which is sold by clinic patients given doses to take at home, has been responsible for at least 2,200 deaths nationally; more than 23,000 people have become addicted to illicit methadone.
- Most of South Florida's clinics allow nearly all of their patients to take home strong doses of methadone — a combination sure to result in some patients illegally selling the drug. Methadone dispensed "to go" was linked to five overdose deaths in Broward and Dade counties during 1980 and 1981.
- Methadone was at least a partial cause of 29 drug overdose deaths in South Florida during 1980 and 1981 — twice the number of deaths attributed to heroin.
- That death toll includes 15 methadone clinic patients — 10 percent of the reported fatalities nationwide during those two years. Only 2 percent of methadone patients nationwide were enrolled in Florida clinics.
- Nationwide during the past 10 years methadone, alone or in combination with other drugs, has been responsible for the deaths of at least 4,417 people and has sickened at least 24,276 people so badly they required hospital treatment.
- The federal government, which has collected masses of information on the methadone program, never has analyzed its data and has slashed regulation of clinics to an all-time low during the past two years.

lished each year. But the booklet contains no findings on methadone. The extent of methadone use has to be calculated from figures published in a different book, which never has been distributed beyond a handful of researchers. Torus, whose division concentrates on drug abuse, didn't know the information existed until told about it by the *News* and *Sun-Sentinel*.

"This is a very bad situation," Torus said. "We need to find out why it is happening and where the drug is coming from."

O'Malley was not so taken aback. "I don't find [the incidence of methadone abuse] surprising," he said. "We know that the stuff is out there on the street."

The findings of the Michigan study should have surprised no one. According to a 1978 survey of nearly 2 million students in New York state public schools, 12,000 high-school seniors said they had sampled heroin and 13,000 said they had tried illicit methadone.

Most officials agree that the amount of methadone available on the street is directly related to two factors: the size of the methadone doses clinic patients receive, and the number of patients allowed to take the drug home with them.

Regulations warn treatment clinics that "The higher the methadone dose, the greater the risks of diversion," and "diversion may occur when patients take medication from the clinic for self administration."

Despite that stated concern about high doses, no government agency ever has advised clinic doctors how much methadone may be too much, and no agency ever has tried to determine how much methadone the average patient receives.

Using government reports showing number of patients treated and amounts of methadone dispensed, the *News* and *Sun-Sentinel* calculated that in 1981, clinics across the country dispensed an average of just more than 40 milligrams per patient per day. FDA officials said the calculation is valid.

In South Florida, most clinics dispense daily doses far in excess of that amount.

According to a nationwide report as of Dec. 31, 1981, six of every 10 patients stabilized on a maintenance dose of methadone were receiving more than 40 milligrams a day. In South Florida, the *News* and *Sun-Sentinel* calculated that eight of every 10 got more than 40 milligrams.

When high doses are combined with large numbers of take-home sales, some methadone is sure to wind up on the street.

A study conducted by Fordham University in New York City during the mid-1970s reported that 48 percent of patients who were allowed take-homes sometimes sold them, and that 20 percent did so regularly.

Federal officials long have been aware that illegal methadone is responsible for what Dr. Robert Dupont, former director of the National Institute on Drug Abuse, called a "painful record of methadone overdose deaths."

But the FDA's efforts to halt diversion have been inconsistent with the agency's stated concern. For years, officials routinely permitted clinics to bend rules governing take-home methadone, and in 1980 FDA relaxed the regulations considerably.

The following year, clinics across the country reported a 3 percent increase in the number of patients who got methadone to take home. South Florida clinics reported a jump in take-home sales of more than 30 percent, twice the increase for the state as a whole.

By contrast, Operation PAR in St. Petersburg allowed only 13.9 percent of its patients to take methadone home during 1981 — and these patients were required to leave the clinic with the methadone locked in a metal box.

"We chose to develop a very, very conservative program," said Shirley Colletti, sponsor of Operation PAR's methadone program. "We are definitely in the minority. We run a tight ship. You will not find methadone on the streets of Pinellas County."

But in South Florida, "We see patients who get addicted to methadone that they bought on the street," said Dr. Pilar Trueba, medical director of Dade County's two publicly financed methadone programs, the Model Cities Treatment Center in Liberty City and the Central Facility in Overtown, near downtown Miami. Those programs are the only South Florida clinics that restrict take-home sales to any degree.

Six of the nine South Florida clinics allowed virtually all their patients to take methadone home in 1981 — sometimes with deadly results.

In Broward and Dade counties, 14 of the 29 methadone-related deaths during 1980 and 1981 were people who apparently were not enrolled in a methadone clinic.

Documents obtained from South Florida police agencies and medical examiners show that methadone sold "to go" by the two methadone clinics in Broward County — Pompano Methadone Treatment Center and Broward Methadone Maintenance Rehabilitation and Research Facility in Hollywood — was found at the scene of five drug overdose deaths during 1980 and 1981.

Two of those victims were clinic patients who abused their legally obtained methadone; three got the drug from a clinic patient.

Christopher Oven, a 26-year-old metalworker, shared an apartment with a client of the Pompano Methadone Treatment Center who was allowed to take his methadone at home because he had not been taking other drugs while enrolled in the program.

At 1:30 a.m. on May 25, 1980, the patient walked out to his car to get two bottles of methadone he kept locked in the glove compartment, according to Fort Lauderdale police reports.

He told police that one of the three-ounce bottles had been half emptied, and the other appeared "watered-down" because the normally reddish liquid looked clear.

The patient then found Oven passed out on the couch, appearing to be "either under the influence of alcohol or some type of drug," according to police records.

It wasn't until the next day that the patient realized Oven was dead, from what later was ruled an overdose of methadone and other drugs.

Kathy Browlett, 24, of rural Dade, also died from "poly-drug intoxication" on May 13, 1980, in the spare bedroom of a friend's Miami Beach home, according to Dade County Medical Examiner's records.

The friend, who told police he was a patient at the Broward Methadone Maintenance Rehabilitation and Research Facility in Hollywood, claimed Ms. Browlett stole his take-home doses while he was sleeping. Toxicology studies disclosed methadone, methaqualone and diazepam, a tranquilizer sold under the trade name Valium, were present in her body at the time of death.

Dr. Dale K. Lindberg, who with his partners Drs. Melvin Stone and Joseph Dorsey operates both Broward clinics, refused to discuss the methadone program with a reporter Lindberg would say only: "We follow all FDA regulations and state law."

Federal regulations permit take-homes on the belief that they are necessary to keep patients, especially those who are working, in treatment. Methadone patients are required to visit the clinic every day for the first three months of treatment. But clinics have the option of closing one day a week to reduce costs, thus allowing even new patients one take-home dose per week.

After three months, clinics may allow a patient to take more doses home if staffers decide the patient can be trusted not to abuse his medicine. Criteria the clinics are required to consider include evidence of stable family life and steady employment.

Some methadone-clinic operators say they cannot be responsible for what a patient does with his methadone after he takes it home.

But other drug abuse experts disagree.

"If you run a methadone clinic you have to take responsibility. It seems to me that the medical profession ought to get involved and take a hard look at these clinics," said Dr. Charles Wetli, deputy chief medical examiner in Dade County.

And Dr. Vernon Patch, a Harvard Medical School psychiatry professor who directed Boston's methadone programs for seven years, said, "If you give take-home methadone a lot of patients will sell it or save some for people who want to get high."

Patch, who was forced by Boston officials to stop giving out take-home methadone, said some of his patients dropped out when take-homes were halted, but most later returned to treatment.

Diversion of methadone also has saddled the government with an expensive problem — an ever-growing number of people addicted to methadone they bought on the street.

Federally funded drug treatment programs have reported that 23,046 of the patients they admitted since 1973 — roughly 3 percent of all narcotics addicts admitted — were hooked on street methadone.

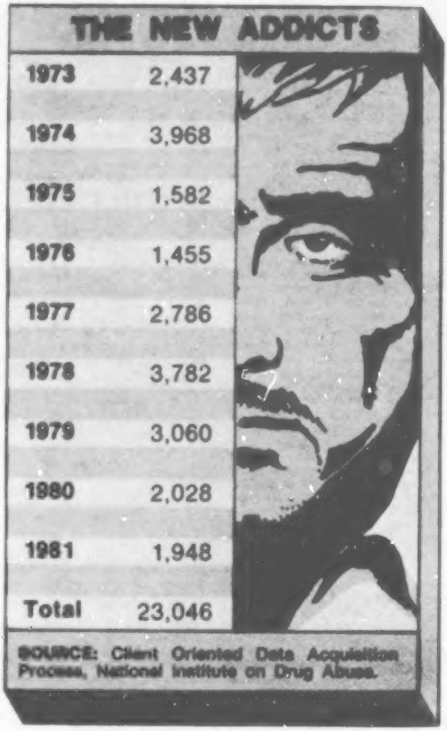
The true extent of addiction to non-prescription methadone is far greater because only about 60 percent of the nation's methadone clinics are federally funded.

Using NIDA figures and research results, the *News* and *Sun-Sentinel* estimated that treatment of these methadone addicts cost $15 million between 1973 and 1981.

The availability of methadone on the street was demonstrated recently by Clyde McCoy, a psychologist at the University of Miami who has studied local drug abuse patterns.

McCoy sent a research assistant to find out whether take-home methadone could be purchased illegally; less than an hour later, the researcher returned with a bottle of take-home methadone that had the name of the patient and the clinic that dispensed it scratched off, McCoy said.

The researcher returned the bottle to the seller; the incident was not reported to police.



THE NEW ADDICTS

1973	2,437
1974	3,968
1975	1,582
1976	1,455
1977	2,786
1978	3,782
1979	3,060
1980	2,028
1981	1,948
Total	23,046

SOURCE: Client Oriented Data Acquisition Process, National Institute on Drug Abuse.

Staff graphic by GALE ENGELKE

Chart shows number of people admitted for treatment of addiction to illegal methadone to federally funded drug abuse treatment programs in the United States. 1973 and 1974 statistics include addicts who reported using methadone along with other drugs; all other years include only those who reported non-prescription methadone as their main drug of abuse.

Illicit methadone sales seldom investigated

The source of the methadone that helped kill Anthony Carl Ricciardi remains a mystery — largely because nobody tried to find out where it came from.

Broward Sheriff's Lt. Mark Schlein found Ricciardi's naked body in the 23-year-old's Lauderdale Lakes apartment on July 23, 1981. The cause of death later was established by the Broward County Medical Examiner's Office as "combined drug poisoning" by methadone and diazepam, a sedative sold under the trade name Valium. No drugs were found in the apartment.

Even though Schlein should have had reason to believe Ricciardi was killed by illegal drugs, he filed no report of the incident and never attempted to learn the source of the drugs. The detective said recently he "thinks" Ricciardi had been enrolled in a methadone program in another state. However, the man had a longstanding local arrest record.

"We can't have the luxury of tracking people who are into drugs back to their associates and suppliers," Schlein said, adding that police investigating such cases routinely do little more than establish that the dead person was a drug abuser before closing the case.

Area police seldom pursue illegal sales of methadone with diligence, even when the drug is involved in a death. Most of their time is taken up with large-scale dealing of illegally imported drugs such as marijuana and cocaine.

Morgue records and police reports from departments throughout South Florida rarely show where a drug was obtained or give any indication that the investigating officer tried to find out.

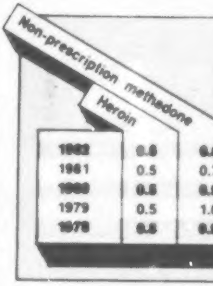
Sheriff's Lt. Mark Schlein

Joseph Ranko's death in February 1978 was an exception.

Ranko, 31, of Miami, chased a diazepam pill with a bottle of methadone that he bought from a patient at the Broward Methadone Maintenance Rehabilitation and Research Facility, 1101 S. 21st Ave., Hollywood, according to witness statements given to Dade County Medical Examiner's Office investigators.

No one was charged in the case, though sale of controlled drugs such as methadone is a crime, police seldom are able to persuade witnesses to testify.

HIGH-SCHOOL SENIORS USING METHADONE



	Heroin	Non-prescription methadone
1982	0.6	0.6
1981	0.5	0.7
1980	0.5	0.9
1979	0.5	1.0
1978	0.8	0.9

More high-school seniors have sampled illegal methadone than heroin, according to an annual study, *Student Drug Use in America*, by the Institute for Social Research at the University of Michigan. Chart of the study's findings shows that while 1 percent or less of seniors questioned during the past five years have tried either of the narcotic drugs, more have sampled illegal methadone than have tried heroin. The research team insists the survey findings are an accurate reflection of drug abuse patterns among the estimated 3.2 million high-school seniors in the nation, which means that 132,000 seniors sampled illegal methadone while only 92,000 used heroin between 1978 and 1982. Neither the National Institute on Drug Abuse, which paid for the study, nor the Michigan researchers have published the incidence of methadone abuse; the information was provided by the Institute for Social Research at the request of the *Fort Lauderdale News and Sun-Sentinel*.

SOURCE: Institute for Social Research, University of Michigan: *Student Drug Use In America*, 1978 to 1982.

“We see patients who get addicted to methadone that they bought on the street.”

— Dr. Pilar Trueba,
medical director
of two Dade clinics

Staff photo by ARNOLD ERNEST

“This is a very bad situation. We need to find out why it is happening and where the drug is coming from.”

— Dr. Edward Tocus,
FDA pharmacologist

Even when police know that methadone and other drugs used with it are being peddled on the streets, little is done to halt it.

Last September, Hollywood police records state, the agency became aware of "numerous citizens' complaints concerning open narcotics violations" in the parking lot of the Hollywood clinic.

A three-day stakeout resulted in the arrest of a man who police said sold pills to clinic patients who had just received their methadone at the clinic. Police also said the man, who was charged with possession of controlled drugs with intent to sell them, was seen to enter the clinic between drug sales.

Department officials could provide no precise numbers of drug arrests near the clinic, but they estimated that "three or four arrests a year occur for selling drugs — including take-home methadone."

"We don't work this clinic as often as we would like," said Sgt. Fred Hobbs of the department's vice and narcotics unit. Drug dealing near the clinic is "sporadic," he said, adding that arrests rarely stem these sales for long.

"It's an uphill fight," Hobbs said.

Strong doses may risk lives of patients

The federal government has been reluctant to advise methadone clinics how much of the drug to dispense to addicts — even though hundreds of patients have died of overdoses.

Food and Drug Administration records reveal that overdoeses make up 10 percent of the 2,177 adverse reactions to methadone recorded by the agency between 1970 and August 1982. Many overdoses involved methadone mixed with other drugs; almost all proved fatal.

Not until 1980 — eight years after the nationwide network of methadone clinics was established — did the FDA decide on any regulation of dosage at all.

In 1980, the agency ordered clinic doctors to give addicts entering treatment no more than 30 milligrams a day; after that, the regulations tell doctors to find a dose for each patient that is large enough to curb withdrawal symptoms but too small to cause euphoria.

"Methadone clinics need some room to maneuver" in setting doses, said Dr. Frank Vocci, a pharmacologist who is deputy chief of FDA's drug abuse staff. "We walk a fine line between doing nothing and doing something that will do more harm than good."

Vocci said he was surprised at the number of clinic patients who died from the effects of methadone. "I have a hard time believing that doses given addicts by methadone programs are killing them. That sounds a little far out," he said.

But his own agency's records state that the 30-milligram limit for new patients was imposed because "There have been cases of overdoses resulting from less-tolerant narcotic-dependent patients receiving too much methadone initially."

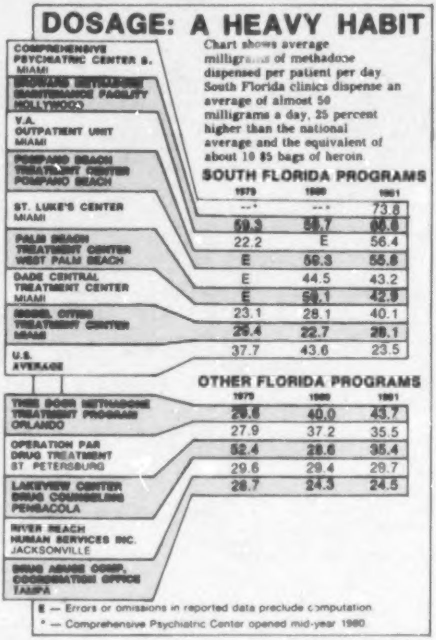
The FDA requires doctors to report all patients who receive more than 100 milligrams a day, but the agency never has offered clinic doctors — many of whom have only limited familiarity with methadone therapy — any other guidelines about how much methadone may be too much.

A dose of 100 milligrams of methadone "is equivalent in potency to perhaps 20 $5 bags of heroin," said Dr. Michael Baden, Suffolk County (New York) medical examiner.

Baden said only a "heavy-duty" addict would need 20 bags of heroin daily to sustain a habit. Many experimental heroin users, those not tolerant to the drug, would use one bag or less, he said.

Many methadone clinics, however, intentionally build patients' tolerance to methadone in an effort to discourage them from seeking out heroin.

Government officials hesitate to



DOSAGE: A HEAVY HABIT

Chart shows average milligrams of methadone dispensed per patient per day. South Florida clinics dispense an average of almost 50 milligrams a day, 25 percent higher than the national average and the equivalent of about 10 $5 bags of heroin.

SOUTH FLORIDA PROGRAMS

	1979	1980	1981
COMPREHENSIVE PSYCHIATRIC CENTER S. MIAMI	--*	--*	73.8
BROWARD METHADONE MAINTENANCE FACILITY HOLLYWOOD	59.3	58.7	60.6
V.A. OUTPATIENT UNIT MIAMI	22.2	E	56.4
POMPANO BEACH TREATMENT CENTER POMPANO BEACH	E	58.3	55.8
ST. LUKE'S CENTER MIAMI	E	44.5	43.2
PALM BEACH TREATMENT CENTER WEST PALM BEACH	E	50.1	42.9
DADE CENTRAL TREATMENT CENTER MIAMI	23.1	28.1	40.1
MODEL CITIES TREATMENT CENTER MIAMI	26.4	22.7	28.1
U.S. AVERAGE	37.7	43.6	23.5

OTHER FLORIDA PROGRAMS

	1979	1980	1981
THE DOOR METHADONE TREATMENT PROGRAM ORLANDO	29.6	40.0	43.7
OPERATION PAR DRUG TREATMENT ST PETERSBURG	27.9	37.2	35.5
LAKEVIEW CENTER DRUG COUNSELING PENSACOLA	52.4	28.6	35.4
RIVER REGION HUMAN SERVICES INC. JACKSONVILLE	29.6	29.4	29.7
DRUG ABUSE COMP. COORDINATING OFFICE TAMPA	28.7	24.3	24.5

E — Errors or omissions in reported data preclude computation

* — Comprehensive Psychiatric Center opened mid-year 1980

Staff graphic by GALE ENGELKE

SOURCE: National Drug Abuse Treatment Utilization Survey; clinic annual reports characterize any amount of methadone as a "high" dose lest doctors accuse the government of trying to dictate the practice of medicine.

FDA regulations enacted in 1972 stated simply that the "usual range" of dosage nationwide was between 40 milligrams and 100 milligrams daily.

In the early 1970s, patients were given as much as 200 milligrams a day. Some experts — including Dr. Vincent Dole, founder of the methadone maintenance program — still believe these high doses are needed.

Dole bristles at the suggestion that large amounts of methadone can be dangerous for maintenance patients.

"If someone is in a methadone program, and taking it at steady doses, he is protected against a narcotic overdose. You can give them three times the dose and they don't feel it. I have yet to see a single case in which methadone caused a death," Dole said.

Between Jan. 1, 1973, and Dec. 31, 1981, methadone clinics across the country reported at least 74 patient deaths due to methadone alone. No reports indicate how many of those patients were "taking it at steady doses."

Others disagree about the need for high doses.

"I have never seen a street habit that could not be managed on less than 30 milligrams of methadone a day," said Dr. Edward Senay, a University of Chicago psychiatry professor who addressed a recent seminar sponsored by the Florida Alcohol and Drug Abuse Association.

A 1973 NIDA study concluded that the "optimal standard daily dose" is 50 milligrams, though the researchers stressed that programs need to tailor the dosage to each patient.

Surveys in 1978 and 1979 reported that the "largest percentage of clients at any given dosage level . . . fell within the 20-to-39-milligram range." NIDA officials did not determine how much methadone the average patient receives each day.

The *Fort Lauderdale News* and *Sun-Sentinel* calculated that nationwide in 1981, methadone clinics dispensed an average of just more than 40 milligrams of methadone per patient per day.

The *News* and *Sun-Sentinel* also found that most South Florida clinics dispense daily doses far in excess of the national average.

Patient death rates in South Florida also greatly exceed the national average, but no government official ever has tried to determine whether the size of the doses might be to blame.

Most illicit methadone 'diverted' from clinics

Illegal methadone usually sells for $1 a milligram in South Florida.

The drug's appearance can vary. Federal laws require that methadone clinics dispense the narcotic in liquid form, most often mixed with orange juice to reduce the chances it can be injected. But the clinics can buy the drug in several forms. If the pre-sweetened syrup is used, an average daily dose would fit in a tablespoon. Some clinics buy 40-milligram tablets, called diskets, which are dissolved in water before patients receive them. In either case, the drug must be dispensed in a small bottle bearing the facility's name. Some clinics refuse to tell their patients the size of the dose in order to minimize requests for increases in medication.

Black-market buyers can't determine the potency of "street" methadone, and therein lies one of the drug's dangers.

Methadone, like all narcotics, can cause breathing to cease in persons not tolerant of the drug. Death results unless medical treatment comes swiftly.

In addition, the drug's intense euphoria can take as long as two hours to begin in some users; the delay may lead them to think the drug is not working. A person who takes other drugs in the interim greatly increases the risk of a life-threatening overdose.

Because methadone sometimes is stolen from clinics and pharmacies that store supplies for clinics, police occasionally find the diskets for sale on the street. But most often, methadone is sold in liquid form, indicating it was "diverted" by a patient trusted to take the drug unsupervised.

'To go:'

FDA must 'take a lot on faith;' overdoses, street sales result

"This is criminal. Before you allow a person to take home [methadone], you should know a lot about that person, whether he is working toward rehabilitation."

— Charles Wetli, Dade County deputy chief medical examiner

Thousands of times since 1974, federal officials have bent their own rules intended to restrict sale of methadone to patients to take home.

All a worker in a methadone clinic had to do was make a telephone call to Washington and assert that a patient was "responsible." The Food and Drug Administration routinely approved most of these requests.

"You could say that we bend the rules," said Daniel P. Hillstrom, deputy director of the FDA's Division of Methadone Monitoring.

But bending the take-home rules can prove deadly.

David Claville, 32, moved to South Florida from Orlando. On May 15, 1982 — a Saturday — he enrolled in Miami's publicly funded Bayshore Treatment Program, now called the Central Treatment Center.

Four days later he was found dead in his room at the Stevens Hotel, 136 NE Ninth St., Miami, an empty bottle of the clinic's methadone by his side.

"Methadone killed him," said Dr. Charles Wetli, Dade County deputy chief medical examiner, who said methadone was the only drug found in the body.

"This is criminal. Before you allow a person to take home [methadone], you should know a lot about that person, whether he is working toward rehabilitation," Wetli said.

Richard Harrington, director of the county division which oversees Dade's methadone programs, called Claville's death an "unfortunate circumstance," but said the newly admitted patient was issued a take-home dose because the clinic had moved that day.

Harrington said his agency had approval from the FDA to dispense take-homes to all patients because of the move, but Hillstrom, the FDA official who handles all such requests from Florida programs, said he could locate "no record" of such a request being made.

Strict rules originally were imposed on take-home methadone because the FDA knew some patients would sell their methadone on the street if given a chance to do so.

"There is always a risk in allowing unsupervised use of methadone," Hillstrom said. "We have to take a lot on faith."

One clinic that asked the government to take a lot on faith was the Broward Methadone Maintenance Rehabilitation and Research Facility in Hollywood. FDA documents disclose that the clinic filed 290 requests for reduced patient attendance during 1978 alone, a number Hillstrom said was "enormous" compared to other clinics in Florida and around the country.

Virtually every request was approved over the phone by a Washington-based bureaucrat who never had seen the patient. Verbal approval was followed by a letter confirming the decision.

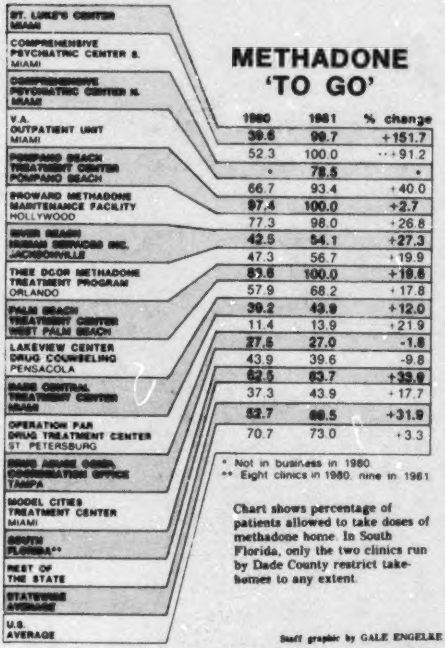
FDA officials defend the need to "bend the rules" for patients who must travel long distances to reach a clinic, or suffer from physical disabilities restricting their movement. Take-home privileges also can be approved for "necessary" travel or other special circumstances if failure to approve them would cause the patient a "hardship." Exactly what constitutes a "hardship" is not specified in the regulations.

Under normal circumstances, all patients are required to drink their methadone at the clinic at least six days a week during the first three months of treatment. If the client "progresses" in treatment, the number of take-home doses can be increased.

The *News* and *Sun-Sentinel* found numerous cases in FDA records in which hardship is questionable, including a cab driver who lived four miles from the clinic, some cases in which "emergency" travel turned out to be trips to Disney World in Orlando, and other instances in which the cited travel never took place.

The sheer volume of exception requests eventually caused the process to collapse. In November 1980 the agency stopped requiring clinics to file these requests because officials were "overwhelmed" trying to answer thousands of requests sought by the 631 methadone programs nationwide at that time. Under the new regulations, methadone clinics can make their own decisions regarding exceptions as long as the reasons for the take-home privilege are recorded in the patient's file.

The relaxed regulations allow a clinic to dispense as many as 14 take-home doses at a time without FDA approval, though the agency still wants to know if a methadone clinic has granted such large-scale take-home privileges to patients.



METHADONE 'TO GO'

	1980	1981	% change
ST. LUKE'S CENTER MIAMI	39.6	99.7	+151.7
COMPREHENSIVE PSYCHIATRIC CENTER S. MIAMI	52.3	100.0	+91.2
COMPREHENSIVE PSYCHIATRIC CENTER N. MIAMI	*	78.5	*
V.A. OUTPATIENT UNIT MIAMI	66.7	93.4	+40.0
POMPANO BEACH TREATMENT CENTER POMPANO BEACH	97.4	100.0	+2.7
BROWARD METHADONE MAINTENANCE FACILITY HOLLYWOOD	77.3	98.0	+26.8
RIVER REGION HUMAN SERVICES INC. JACKSONVILLE	42.5	54.1	+27.3
THEE DOOR METHADONE TREATMENT PROGRAM ORLANDO	47.3	56.7	+19.9
PALM BEACH TREATMENT CENTER WEST PALM BEACH	83.6	100.0	+19.6
LAKEVIEW CENTER DRUG COUNSELING PENSACOLA	57.9	68.2	+17.8
DADE CENTRAL TREATMENT CENTER MIAMI	39.2	43.9	+12.0
OPERATION PAR DRUG TREATMENT CENTER ST. PETERSBURG	11.4	13.9	+21.9
DRUG ABUSE COMP. COORDINATION OFFICE TAMPA	27.5	27.0	-1.8
MODEL CITIES TREATMENT CENTER MIAMI	43.9	39.6	-9.8
SOUTH FLORIDA**	62.5	83.7	+33.9
REST OF THE STATE	37.3	43.9	+17.7
STATEWIDE AVERAGE	52.7	69.5	+31.9
U.S. AVERAGE	70.7	73.0	+3.3

* Not in business in 1980

** Eight clinics in 1980, nine in 1981

Chart shows percentage of patients allowed to take doses of methadone home. In South Florida, only the two clinics run by Dade County restrict take-homes to any extent.

Staff graphic by GALE ENGELKE

SOURCE: Annual reports to U.S. Food and Drug Administration.

Missing drugs often go uninvestigated

The federal Drug Enforcement Administration is notified of as much as $400,000 worth of methadone stolen from Florida clinics and pharmacies each year.

The agency seldom investigates the thefts, insisting that is the duty of local police. Yet local police often aren't told of the thefts, because DEA rarely passes the word on, said Harold Dieter, director of the administration's Bureau of Compliance in Miami.

"All break-ins and robberies are reported to police," Dieter said, but he conceded that if there is no indication of a break-in, local police might not hear about an incident involving missing methadone.

As a result, some cases of missing methadone — particularly those in which no evidence of burglary is present — go uninvestigated. They remain entries in DEA's computers.

Among the instances uncovered by the *Fort Lauderdale News* and *Sun-Sentinel*:

- The St. Luke's Center in Miami reported that on March 13, 1980, four one-quart bottles of liquid methadone were missing from a shipment delivered to the clinic. The head nurse reported that the theft was not discovered until after the package had been signed for. In the future, according to the DEA report, St. Luke's officials promised to "open and inspect containers of merchandise before delivery receipt is signed."

● On Dec. 18, 1980, one of three nurses working at the Bayshore Treatment Center in Miami discovered that 850 milligrams of methadone — enough for about 20 average doses — was missing.

Clinic officials reported the disappearance of the drug, worth about $850 on the black market, to DEA agents in Miami, but DEA records contain no indication that the disappearance was investigated or turned over to a police agency for investigation. The drugs never were recovered. Clinic employees were not disciplined.

● During January 1979, Dr. W.W. Andrews, medical director of the DAACO Chemotreatment Program in Tampa, reported to DEA that nearly 100 milligrams of methadone had "accidentally spilled" over a period of several days, according to DEA records. Three months earlier, DEA agents had discovered 22 occasions on which individual doses of methadone prepared for clients vanished before the patients arrived.

Eighteen months after the "spill," Andrews reported to DEA that a quart bottle of liquid methadone "was broken when it was moved from one surface to another." His report contained no further details, and the DEA never asked for more information.

● On March 29, 1978, shortly after Dr. Bernard Milloff opened the Pompano Methadone Treatment Center in Pompano Beach, he discovered that a quart bottle of liquid methadone was "missing from the clinic safe." Because there was no evidence of forced entry, he notified DEA that he planned to give his employees lie-detector tests. The DEA could locate no record that the incident ever was investigated further.

Other methadone was lost in clinic break-ins and thefts from pharmacies and wholesalers.

● On Jan. 15, 1981, the Comprehensive Psychiatric Center South in Miami experienced one of the largest methadone thefts in Florida history when an armed robber stole methadone valued at more than $200,000. That incident was investigated by the Metro Dade Public Safety Department, but the drugs never were recovered.

● One Miami pharmacy that stocks methadone for sale to area clinics reported a theft of $100,000 worth of methadone during an armed robbery early in 1979.

Thefts have plagued methadone centers since the programs began operating. News of one Broward burglary in 1973, a time when federal officials were struggling to curb diversion of the drug, was forwarded to White House officials.

On May 31, 1973, someone carted a 750-pound office safe from the Broward Methadone Maintenance Rehabilitation and Research Facility in Hollywood; the safe contained 97,960 milligrams of methadone, $1,617 in cash, and seven prescriptions for methaqualone and diazepam (Valium) prepared in advance for clinic patients, according to an investigative report filed by agents with the Miami office of the Bureau of Narcotics and Dangerous Drugs (now DEA).

Because there were no signs of forced entry, agents speculated that the burglars hid in a storage closet until the clinic closed, then loaded the safe onto a dolly and into a van. Agents visited the clinic two months later and, finding that the safe had been replaced by an alarm-equipped model, closed the case.

Legal methadone pills also hit black market

Not all methadone abused in South Florida is the liquid dispensed by addiction-treatment centers.

The drug also comes in pill form — Dolophines, prescribed to treat severe pain. Occasionally these pills are stolen from pharmacies.

George Downs, a 29-year-old Hollywood resident, died on March 14, 1981, after buying 20 of the 10-milligram pills for $120. They were purchased from a woman Downs and his girlfriend knew as "Joan," on Ives Dairy Road in north Dade County, according to police reports.

The girlfriend, who identified herself to police as a heavy methadone user, said Downs took four tablets, totaling less than the average daily dose handed out by South Florida clinics.

Sometime during the night Downs died, apparently in his sleep. The cause of death was listed in Broward County Medical Examiner's records as "methadone poisoning."

Dolophines were reported stolen from eight Florida pharmacies during 1982, according to Drug Enforcement Administration documents.

The federal Food and Drug Administration, in the early days of the methadone program, tried to prohibit pharmacies from stocking the pills. But the ban was overturned by a federal judge who ruled that the FDA had exceeded its authority.

HELP FOR SO FEW

90% can't shake off addiction

Bob is hooked on methadone. Like hundreds of other addicts, he gets a daily "fix" at one of South Florida's nine dispensing clinics.

He has been in and out of methadone treatment since 1969. When he gets sick of being "hassled" by methadone clinic staffers, he drops out, returning to "street" narcotics for as long as his money holds out.

"Coming off methadone is real bad," Bob said. "I can't put it in words, but your brain has pain. You are so screwed up you get disoriented for months and can't get nothing together."

Bob, 35, asked that his last name be kept confidential. Like thousands of others who enter methadone treatment, he has been unable to shake his dependence on drugs.

A *Fort Lauderdale News* and *Sun-Sentinel* examination of government records — statistics the government itself never has reviewed — disclosed that nationwide, only about one of every 10 addicts who enroll in methadone maintenance clinics is cured of drug use. Half never complete the treatment.

Each year more people shuttle in and out of methadone clinics, alternating between street drugs and clinic-supplied methadone and unwilling or unable to end their addiction.

To many professionals in the field, the low "cure" rate doesn't mean methadone treatment is a failure.

"My goal is cleaning up the streets," said Dr. Pilar Trueba, medical director of Dade County's two tax-funded methadone programs. "I feel I've been a success even if the patients are still addicted. I'd rather see them on methadone than on the streets committing crimes and going to jail."

Others disagree. Dr. Joseph Deatsch, medical director of River Reach Human Services Inc. in Jacksonville, noted that the goal of his program is to encourage patients to stop taking all drugs, including methadone, as quickly as possible.

A FUTILE EFFORT

Government-funded methadone maintenance programs nationwide cure few people of drug use — and the programs' track record has been getting worse since 1979. What the government calls "satisfactory outcomes" — the percentage of clients cleansed of all drugs plus the percentage of clients released from treatment even though they are still using some drugs — have been dropping, and percentages of clients who were kicked out of the programs or who dropped out voluntarily before completing treatment have been rising. Percentages don't add up to 100 because patients who transferred from one clinic to another were excluded.

	drug free	completed, some drug use	kicked out	dropped out	jailed	died
1977	**11.0%**	**4.4%**	**12.3%**	**45.0%**	**—***	**—***
1978	12.3%	3.9%	9.2%	40.6%	8.5%	1.2%
1979	**14.0%**	**4.0%**	**10.4%**	**38.1%**	**8.4%**	**1.2%**
1980	11.7%	3.8%	12.4%	39.3%	7.9%	1.2%
1981	**9.3%**	**3.6%**	**15.1%**	**39.8%**	**8.9%**	**1.0%**

*Not computed.

SOURCE: Client Oriented Data Acquisition Process, National Institute on Drug Abuse.

Staff graphics by GALE ENGELKE

Methadone: The facts

- Methadone treatment ends with only one of every 10 addicts who try it free of drugs. Some addicts are able to live a relatively normal life on methadone, but each year more become trapped in a closed cycle of addiction, dropping in and out of treatment and alternating between street drugs and clinic methadone.
- Illegal methadone, much of which is peddled on the streets by clinic patients given doses to take at home, has been responsible for at least 2,200 deaths nationally; more than 23,000 people have become addicted to non-prescription methadone in the past decade.
- Most of South Florida's methadone clinics allow almost all of their patients to take home very strong doses of methadone — a combination sure to result in illegal diversion. "To go" methadone was linked to five overdose deaths in South Florida during 1980 and 1981.
- Methadone was linked to 29 drug overdose deaths in South Florida in 1980 and 1981 — twice the number attributed to heroin.
- That death toll includes 15 methadone clinic patients — 10 percent of the reported fatalities nationwide during those two years. Only 2 percent of methadone patients nationwide are enrolled in Florida clinics.
- During the past 10 years methadone, alone or in combination with other drugs, has been responsible for the deaths of at least 4,417 people and has sickened at least 24,276 people so badly they required hospital treatment. At least 68 fatalities were unborn children carried by methadone-using mothers.
- The federal government's attempt to protect patients from poor care by the methadone clinics has been slashed to an all-time low during the past two years.
- The federal agencies that sanctioned the drug's use and supervised its distribution through tax-subsidized clinics have collected masses of information about the methadone program but never have analyzed the data.

"I am denying my patients the opportunity to be a success if they are denied a chance at a drug-free life," Deatsch said.

He conceded, however, that only a "moderate" proportion achieve that goal.

Federal reports indicate that from 1979 to 1981 only 4.5 percent of clients treated at Dr. Trueba's clinics — the Bayshore and Model Cities treatment centers — rid themselves of all drugs. The Jacksonville clinic reported that 9 percent of its clients became drug-free during the same period.

Even Dr. Vincent Dole, the New York researcher whose original tests of methadone maintenance indicated that most patients would end up as productive citizens, admits the treatment has not lived up to its promise. He blames that failure on lack of adequate counseling and job training provided by methadone clinics.

"The reason that methadone has not achieved rehabilitation is because of rigidly bureaucratic regulations and overcrowding" at clinics, Dole asserted. "The medicine is not at issue. It is the services that are being provided."

Dole's tightly controlled tests of maintenance theory, which included intensive counseling, indicated about 85 percent of patients kept on methadone would stop using heroin and become productive members of society.

But the record of the nation's methadone programs has been much worse.

"When you get out in the field, you find that the average clinician who dispenses methadone doesn't give patients the love and attention that Dole did," said Dr. Saul B. Sells, director of the Institute of Behavioral Research at Texas Christian University. "When methadone maintenance got too big, it lost the personal touch. Methadone by itself won't rehabilitate anyone."

Federal Food and Drug Administration regulations virtually ignore the role of counseling and job training in methadone therapy — even though FDA approval of the drug was based on its use "in conjunction with appropriate social and medical services."

Methadone clinics are required only to "make available" these services; some clinics do that by simply posting a list on a bulletin board.

Reports from federally funded clinics across the country — about 60 percent of all licensed methadone programs — indicate that rehabilitation for patients is virtually non-existent.

Those reports, collected through the government's Client Oriented Data Acquisition Process (CODAP), show that since 1977, less than 2 percent of patients who have left methadone maintenance completed job training, and only one in 10 found a job while in treatment.

The clinics' best year, according to CODAP reports, was 1979, when 14 percent of clients were released free of drugs.

Most government officials are reluctant to use the word "cure" when talking about the methadone program. They prefer to talk about "successful outcomes" — patients who leave treatment drug-free *plus* patients who are released from treatment even though they continue to use some drugs.

But even "successful outcomes" shown in the CODAP reports peaked in 1979 at 18 percent of all patients in methadone maintenance. The percentage has been dropping ever since.

Figures on the performance of Florida clinics are harder to find; officials could locate Florida reports only for 1979 and 1980. During those two years only 9 percent of patients in methadone maintenance were discharged drug-free.

Many maintenance patients do not get full benefit from the treatment because they drop out before completing the program or are kicked out for violating clinic rules.

Federal officials knew when the nationwide methadone program was set up that many addicts who entered treatment would not finish. Dole's initial studies indicated that at least one of every five patients admitted to treatment would drop out, and other studies indicated the dropout rate could be much higher.

Dr. Stuart Nightingale was an official with the Nixon administration's Special Action Office for Drug Abuse Prevention when he wrote, in a December 1972 memorandum for officials of the World Health Organization:

"Factors which affect retention in methadone maintenance programs are varied but are known to be based on such factors as morale, management, approach to medication, take-home privileges, and stability of the individual addict enrolling in the program. The drop-out rate over the first year for most methadone programs, however, seems to range from 20 percent to 50 percent, regardless of the variables."

Nightingale now is assistant secretary for health in the Food and Drug Administration.

Since 1977, according to CODAP

CAUGHT IN A REVOLVING DOOR

Each year more people shuttle in and out of methadone clinics, alternating between street drugs and clinic-supplied methadone. The *News* and *Sun-Sentinel* determined that early in the national methadone program, first-time clinic patients outnumbered returnees by almost 4-to-1; by 1981, repeaters outnumbered new patients 3-to-1.

	Admissions Not Treated Before	Admissions Treated Before
U.S.		
1974	43,230	11,750
1975	48,106	15,677
1976	33,032	12,646
1977*		
1978*		
1979-80	13,524	32,349
1981	12,293	36,348
FLORIDA		
1974	1,370	449
1975	727	373
1976	1,225	627
1977**		
1981	1,158	1,497

*January 1977 Through April 1979 Not Available
**Through 1980 Not Available

SOURCE: National Drug Abuse Treatment Utilization Survey; Clinic Annual Reports

reports, more than 52 percent of maintenance patients who left treatment either dropped out or were kicked out.

"If dropout rates are that high, the clinics are not being very effective. Something is missing. I don't know what it is," said Dr. Edward Tocus, a pharmacologist who directs FDA's Division of Drug Abuse.

The federal government has spent millions of tax dollars to collect statistics on methadone programs, but no one has tried to determine why patients drop out before completing treatment.

"I don't know from these studies why these people split," said Dr. James Cooper, director of medical and professional affairs for the National Institute on Drug Abuse.

Cooper said the CODAP computer studies funded by his agency were "management tools," of no use in determining whether methadone has been an effective treatment.

"There are so many poor methadone programs around that these agencies get defensive," said methadone founder Dole. "These [dropout] numbers are the very first index of success. If one-half of your patients are [dropped out or kicked out] within a year, then something is wrong with your program."

Cooper disagrees that anything is wrong with methadone and disputes CODAP statistics that indicate the treatment leaves few patients free of drugs. He claimed that one study of the outcomes of various treatments given to 44,000 heroin addicts nationwide showed that three of every 10 patients treated with methadone were cured.

But even that study, a 10-year effort by TCU's Sells, showed that methadone maintenance was less effective than other treatments.

Methadone maintenance, according to the Sells study, cured 29.5 percent of its patients of drug use; two other types of treatment stressing abstinence from drugs achieved success in 36.9 percent and 34.4 percent of patients.

When the nationwide methadone program was set up, federal officials had argued that "drug-free" programs rarely worked.

The Sells study also reported that 21 percent of the sample heroin addicts ended up free of drugs even though they received no treatment at all.

"Nature has a way of healing itself," Sells said.

Even patients who complete a course of methadone treatment and become drug-free may not stay that way for long. Though no specific figures are available, some researchers suggest that for many, the cure doesn't last.

"The retention of methadone's effects [once treatment is stopped] is not significant," said Clyde McCoy, a University of Miami psychologist who has studied the issue. "Many patients complete treatment but go back to their old ways."

Enrollments in treatment programs have been rising since 1979, and many of those patients have been there before. Using FDA annual reports and surveys by the National Institute on Drug Abuse, the *News* and *Sun-Sentinel* documented that in 1974, addicts seeking treatment for the first time outnumbered patients previously enrolled in methadone programs almost 4-to-1; by 1981, returnees outnumbered first-timers by 3-to-1.

"Basically most methadone clinics are revolving-door operations," said Frank Nelson, director of drug abuse treatment services for the Florida Department of Health and Rehabilitative Services. "For many clients, addiction is a chronic and recurring illness."

But many of those involved in drug abuse treatment reject the notion that once a person becomes an addict he always will need drugs.

"We tend not to believe in that," said Jerry Feulner, administrator of Thee Door in Orlando. "Our program is much much more behaviorally oriented."

Feulner said his counselors recognize that patients are dependent on drugs, but they believe "that drug addiction can be controlled. It is a question of motivation," he said.

Feulner concedes that many methadone patients lack motivation. They enter treatment only when supplies of street drugs dry up, then drop out when they are able to get good heroin. Others who try to continue abusing drugs while on methadone are kicked out of the programs, only to be readmitted later.

Other patients remain in the system for long periods of time without making any effort to free themselves from drugs. Some of these patients stay in treatment just to get drugs; others truly believe they can't live without methadone.

Patients such as Tim, another South Florida methadone patient, insist they feel more than the flu-like symptoms associated with narcotics withdrawal when they try to kick methadone — or even when the effects of their most recent dose start to wear off.

"Methadone is like blood to me," Tim said. "I need the stuff."

FDA officials have mixed feelings about these patients. Though the agency believes the ultimate goal of methadone is to free an addict from dependence on any drug, officials believe patients stabilized on methadone can be considered a success. The agency also requires clinic doctors to review the files of these patients every two years and to provide written justification for continuing the patient on methadone.

But studies of methadone programs in the early 1970s indicated that addicts older than 35 were the most likely to remain in treatment. One study, conducted by researchers at Columbia University, stated that this finding had "grave consequences for the success" of methadone programs, "mostly because the people are getting addicted younger, and the younger the onset of addiction, the more difficult these people are to keep in treatment."

Whether long-term maintenance is in the best interests of the patient remains unanswered. Experts in the field note that keeping an addict on methadone treatment for a long time can be troublesome, particularly as the patient ages. Some believe that heroin addiction is a disease that burns out as addicts enter their 30s, largely because they get tired of the addict's lifestyle.

"There is a very real danger of keeping people too long dependent," said Dr. Herbert Kleber of Yale University.

Methadone critics contend that the federal funding setup encourages some programs to lock patients into addiction because clinics are paid by the government based on the numbers of patients they treat.

"People who run these clinics get money to maintain addicts," said Dr. Delores Morgan, medical director of South Miami Hospital Addiction Treatment Center. Her center, which does not provide methadone maintenance, requires patients to become free of drugs.

"If they cut the numbers of patients, then their budgets get reduced," Ms. Morgan said. "By cutting the number of patients, they are cutting their own throats."

DROPOUTS: FLORIDA

	Clinics Inspected	% Dropped Out	% Kicked Out	% Of Those Terminated Later Readmitted
1977	**5**	**55.4**	**2.5**	**33.3**
1978	8	50.6	6.4	25.5
1979	**8**	**53.5**	**5.5**	**16.9**
1980	9	62.6	3.3	16.7
1981	**7**	**41.7**	**5.7**	**18.6**

SOURCE: Clinic inspection reports, U.S. Food and Drug Administration.

The *Fort Lauderdale News* and *Sun-Sentinel* compiled information on dropouts from methadone treatment in Florida from reports on clinic inspections. The tally is not complete because not all clinics in the state are inspected each year.

DROPOUTS: U.S.

	Number of Patients	% Dropped Out	% Kicked Out
1977	**26,465**	**45.0**	**12.3**
1978	25,900	40.6	9.2
1979	**22,775**	**38.1**	**10.4**
1980	24,751	39.3	12.4
1981	**24,436**	**39.8**	**15.1**
Five-Year Averages:	24,865	40.6	11.9

SOURCE: Client Oriented Data Acquisition Process, National Institute on Drug Abuse. Includes only federally funded clinics (about 60 percent of the clinics in the country).

Nationwide, terminations have increased steadily since 1979.

U.S. 'assumes' MDs are trained, but many aren't

Retired urologist Joseph Perry was hired to run the Pensacola methadone clinic in 1975 even though he admitted a "lack of knowledge in the area of drug abuse," according to federal records.

Perry told a federal inspector in January 1976 that because he didn't know much about drug abuse, he spent three-fourths of his time dealing with alcohol abusers also treated by the agency.

The inspector — and another reviewer who checked the clinic's records almost two years later, after Perry's departure — sharply criticized the clinic for failing to document that several clients were narcotics addicts upon admission.

Perry, who has died, was one of at least 42 doctors who have operated methadone programs in Florida in the past 10 years even though they had no training.

"A naive [untrained] physician who undertakes to run a methadone program must be soft in the head," said Dr. Vernon Patch, a Harvard University psychiatry professor who formerly operated the city of Boston's programs. "Addicts will run rings around the average doctor."

The U.S. Food and Drug Administration requires only that the doctor in charge of a methadone clinic have a medical license and a permit to dispense narcotics. "We assume that the doctors have experience" in treatment of drug abuse, said L. Yvonne Covington, acting director of the FDA Division of Methadone Monitoring.

But most doctors did not have experience when they were hired to run Florida programs, judging from their resumes. Just 14 of 56 resumes, which were obtained by the *Fort Lauderdale News* and *Sun-Sentinel* from FDA, list experience in treating drug abuse; only three stated previous affiliation with a methadone program.

"That does surprise me," said Daniel P. Hillstrom, the monitoring division's deputy director. But he said that his office probably couldn't do anything about it.

"I don't think we could raise an objection" to lack of training, Hillstrom said. "I suspect that we don't have the authority to do that."

Under FDA regulations the program sponsor is legally responsible for a methadone program, but the agency doesn't require program sponsors to know anything about methadone treatment either. Indeed, many sponsors' duties are administrative.

While a few Florida methadone programs have been plagued by physician turnover, most have been able to retain physicians in recent years; though many of the doctors learned the techniques through on-the-job training they now have years of experience.

But experience in treating addicts has not halted FDA criticisms of medical care provided to patients.

Violations of federal standards during the past 10 years include:

- Formal treatment plans, with demonstrated goals for patients, are sketchy or missing from some patient files. In other cases, medical evaluations were not performed even though such a review is required to justify enrollment in the program beyond two years.

- Changes in patients' dosages have occurred without written justification by the program physician. Government officials note that frequent requests for adjustment by a patient may indicate that the patient is abusing other drugs, or trying to boost methadone euphoria.

- Failure to test patients for signs of unauthorized drug use.

"We never say that a program is not providing sound medical care. We say their records don't reflect it," Mrs. Covington said.

The FDA never has done more than reprimand a clinic and never has given evidence of substandard medical care to state authorities.

Florida's Medical Practice Act subjects physicians to penalties ranging from a reprimand to loss of license for undertaking medical services which the doctor "knows or has reason to know that he is not competent to perform."

Failure by a physician to keep "written medical records justifying the course of treatment" also is a violation of state medical licensing law. These records have been absent from many patient files reviewed by FDA inspectors.

Late in 1980 government officials relaxed regulations that required one full-time doctor for every 300 patients. Many of the doctors worked only part time at the clinics, maintaining private practices.

Now, the clinics don't have to have any full-time physicians.

Boasts cloud the crime debate

Federal drug abuse treatment officials claim every tax dollar spent on drug abuse treatment prevents $20 worth of crime. But they concede that figure is based on estimates which are difficult to confirm or dispute.

In 1981 — 10 years after Nixon administration officials argued that methadone maintenance would reduce crime — National Institute on Drug Abuse officials announced that "for the first time" they had been able to "clearly document" criminal activity of heroin addicts.

The estimate was based on interviews with addicts who claimed they were responsible for as much as one major crime per day each. Many researchers discount this claim, however, because they think addicts frequently exaggerate the extent of their drug habits and the crimes they commit.

NIDA officials claim that reduced use of illicit drugs is likely to reduce criminal behavior, but a study of 118 methadone patients enrolled in Atlanta programs, published in *The American Journal of Public Health* in 1974, showed "no changes" in thefts and violent crimes between patients and those untreated.

Government data suggest methadone also has contributed to some crime. In the mid-1970s, officials found that as many as 48 percent of New York methadone patients illegally were selling doses of the drug they were permitted to take at home.

NIDA paid for that research project but declined to publish all the findings; instead, officials published an abbreviated version which suggested that illegal sale of methadone was a minor problem.

Many clinics neglect counseling

Federal monitors felt counselors at Tampa's methadone program were falling down on the job.

"Counseling sessions frequently centered on medication problems, increases in doses, take-home and travel privileges," reads a 1975 evaluation of the DAACO Chemotreatment program. "These problems should not be the focus of counseling. Methadone should be viewed as an adjunct to therapy, not the therapy itself."

The government reviewers accused the clinic staff of "wielding methadone as a club."

But the regulators didn't specify what the clinic was *supposed* to do.

Government officials never have spelled out what types of services should be rendered to methadone clients. Regulations simply require clinics to make comprehensive rehabilitative services "available."

Neither the National Institute on Drug Abuse nor the Food and Drug Administration has set standards for counselors, stating only that the workers should be "qualified by virtue of experience, training or education." Counselors range from former addicts to college graduates in social work.

One counselor is required for every 50 patients, but the regulations do not specify how often each patient must meet with a counselor. There is nothing to stop a clinic from simply allowing patients to come in and get the drug.

Some clinic operators insist they do more than simply dispense narcotics and collect fees.

"We are running a methadone treatment program, not a methadone maintenance program," said Jerry Feulner, administrator of Thee Door in Orlando. "Our patients have to commit to regular counseling and within a reasonable period of time get gainfully employed."

But documents obtained by the *Fort Lauderdale News* and *Sun-Sentinel* show that most Florida clinics have been criticized repeatedly by federal inspectors for failing to maintain treatment plans indicating that patients are pursuing rehabilitative goals.

And Florida is not unique:

- A study done for the National Institute on Drug Abuse to evaluate agency-funded programs found that 12 percent of 24,000 files reviewed between July 1976 and May 1977 contained no treatment plan.
- The quality of rehabilitative services offered nationwide was criticized in 1979 by auditors from the Inspector General's office of the U.S. Department of Health and Human Services.

Jerry Feulner, of Thee Door

- The General Accounting Office in 1980 reported finding that even when treatment plans were present in patient records, a patient's goals often were vague, such as "to calm down" and "to have goals for life." GAO auditors also criticized what they termed "low levels" of patient counseling and suggested this might be responsible for the "large number of clients leaving the programs and the high rate of recidivism."

- A New York legislative commission, in a December 1981 audit of the state's methadone programs, also found treatment goals included entries such as "increased tolerance for frustration."

Methadone founder Dr. Vincent Dole believes that government's failure to insist upon rehabilitation — particularly job training — is the reason methadone therapy has failed to cure most addicts.

"The best thing to do is to get an addict a job. If a guy is unemployed, it is a very strong temptation to sell his methadone on the street," Dole said.

But Feulner notes that "job training is a very expensive proposition," one the clinic cannot afford. "Patient fees and funding are not near enough to support the clinic," he said. "The public support is just not there."

Job training is not realistic for many patients in Florida programs, he said.

"A lot of our people have skills. They are not losers that you find in the big cities," Feulner said.

A cure

'Nobody else but me could do it'

For five years, Jimmy Pascrell's life revolved around the two-ounce container of sweetened liquid methadone he drank every morning.

Pascrell, a construction worker who lives in west Broward County, was a patient at the Pompano Methadone Treatment Center.

"Methadone was like having to take your car to the filling station every day," he said. "It bothered me psychologically because I was hooked and buying drugs to get high."

But it was through methadone that Pascrell was able to end a 10-year history of heroin addiction. Last year, he "detoxed," after arguing repeatedly with the clinic staff.

"I decided that nobody else but me could do it," he said. "I had to lock myself in the house."

But methadone wasn't quick to bring stability to Pascrell's life; he dropped in and out of treatment, always returning to street drugs.

In a 1981 interview Pascrell talked about how he had "detoxed" from drugs a hundred times, and could live without them, and soon would be able to.

He spoke disparagingly about the clinic and about staffers' efforts to counsel him; he admitted berating staffers with allegations that they conspired to reduce his dose — one of the objectives of the treatment.

But unlike many patients, who at best wind up in a holding pattern, at worst abuse the treatment, Pascrell changed his ways.

He now says his worst vice is stopping for a beer after work.

"Some people can get off drugs, others can't," said Pascrell, 31.

Drugs of one sort or another had dominated Pascrell for the better part of his adult life.

His use of narcotics began during a stint with the U.S. Army, after Pascrell landed in Guam instead of war-torn Vietnam. He found opium.

~~At first~~ he snorted the drug feverishly. When inhaling failed to sustain him, he began injecting it with a syringe until his arms were covered with needle marks.

Pascrell couldn't hide his habit from Army officials, who at the time were increasingly worried about drug use in the military. The Army booted him out.

Broke, unreformed and having little desire for work, he landed home on the streets of Passaic, N.J., in 1971. Heroin became his new fascination.

He peddled the drug on the streets, always reserving the highest-quality dope for his own use.

But Pascrell rarely made enough money to support his habit or managed to evade police. By the time he was 18, he was sentenced to six months in the county stockade for possession of heroin and narcotics paraphernalia.

That run-in with the law was followed by a succession of drug treatment programs, none of which worked, then methadone beginning in 1977.

Pascrell drifted in and out of treatment for five years, sometimes shuttling between methadone programs in New Jersey and South Florida, sometimes picking up dilaudid on the street; then he decided to quit.

"Right now I'm holding steady," he said.

A success

'The way out was methadone'

Ten years ago George Ferrell lay in the Veterans Administration Medical Center in Miami recovering from a near-fatal bout with hepatitis.

"The doctors said if I didn't stop injecting heroin it would kill me," said Ferrell, who contracted hepatitis from a contaminated needle after more than 20 years of heroin use.

Ferrell enrolled in Dade County's publicly funded Central Methadone Facility and has steered clear of heroin during most of the 10 years he has been a patient there. Instead of spending hundreds of dollars a week to buy heroin, he pays about $30 weekly for methadone, drinking one dose at the Miami clinic and taking six bottles home with him.

"I'm positive that methadone was the only thing that saved my life. For me the way out was methadone," said the short, slim Ferrell, now 51. "It was the greatest thing I could have done."

Ferrell now is a co-owner of a successful gas station in northwest Miami. Though he knows he still is addicted to methadone, he considers himself rehabilitated.

"I'm satisfied with the way things are because I can function normally," Ferrell said, relaxing over coffee at a Miami restaurant. "Getting off drugs completely haunts my mind, but I haven't got any idea when that time will come."

Some experts believe the only successful patient is one who quits all drugs — including methadone. Others consider clients like Ferrell a success even though they remain on methadone for years.

These days Ferrell shows no outward signs of drug use. He laughs easily even when recalling the "miserable" life he lived scrounging for drugs, a life he said began when he worked as chauffeur to a gang of Miami con men who used heroin.

He remembers feeling a "relaxing sensation" when he first inhaled heroin. Within a few years he started "firing," injecting the drug into his veins.

"That was the straw that broke the camel's back," he said. "From then on, it was another job I made for myself, just keeping up and surviving."

When Ferrell first enrolled in the clinic, he tried using heroin with his methadone. And for two years he took advantage of the large doses administered by the clinic to get "high."

"I was so high on methadone I couldn't talk. It was embarrassing because some days I had to go home from work and sleep because I couldn't concentrate," he said.

He persuaded clinic officials to reduce his dose from 75 milligrams daily to his current level of 30 milligrams — low by South Florida standards. He said the dose is too small to produce euphoria but enough to suppress withdrawal symptoms.

Ferrell considers himself one of a fortunate minority of addicts who methadone has helped.

"So many people go through these clinics, but most don't have the desire to get out of the street life," he said. "I've known a couple hundred of them. Some of them have gone downhill, some of them have died [from drug overdoses], and some got good jobs, but they still sneak around and get drugs every once in a while."

But he still worries that he might relapse.

"I've been evading the fact that I got to get away from [methadone]," he said. "I dread that because I detest any ill feeling."

Slot funding: An incentive for abuse?

More than $1 billion in tax money has been paid to methadone programs through a complex and controversial formula called "slot funding."

A "slot" represents one patient in treatment for one year. Each year, based on the amount of money available, the National Institute on Drug Abuse sets a maximum dollar amount for each slot assigned to each type of treatment.

Administrators of drug treatment clinics estimate the number of patients they will treat and compute an annual clinic budget. That budget is divided by the number of clients to arrive at a cost per patient-year.

NIDA pays the clinic 60 percent of that figure, up to the maximum slot allocation; the rest of the facility's budget must come from state and local taxes or client fees.

A clinic gets no additional federal money if it has more patients than it has slots.

This year, the nine publicly funded methadone clinics in Florida are assigned a total of 1,051 methadone treatment slots. In May, those clinics were treating 1,102 patients.

If the federal government reimburses clinics at $2,000 per slot — the 1981 ceiling — that's more than $2.1 million in federal money for Florida clinics alone. The federal government's national methadone budget is about $73 million annually.

During four years — 1976, 1977, 1978 and 1980 — for which nationwide figures could be obtained, the National Institute on Drug Abuse spent $265,495,000 on methadone maintenance programs. Assuming that figure represents 60 percent of the total, the nationwide cost to taxpayers during those four years was more than $442 million.

The NIDA funding method is complicated because the agency pays different rates for different types of treatment. For example, during 1980 and 1981 outpatient methadone clinics could get a maximum of $2,000, while residential treatment facilities were eligible for $5,840.

Some critics charge the payment system encourages programs to keep drug abusers in treatment for too long, and to manipulate statistics to retain funding.

Others have complained that the system contains no incentive to provide high-quality service, because a clinic gets the same amount of money whether it counsels a patient once a month or every time he enters the clinic for his methadone.

Slot funding was devised by bureaucrats in the Nixon White House who in the early 1970s developed the concept to begin the flow of massive amounts of federal money to clinics across the country.

Officials planned to pay about $5,000 to treat each addict in residential settings aimed at getting the addict completely free of drugs; but the methadone maintenance program, which would operate through outpatient clinics, could be run for much less. In 1972-73, the first year of the national program, clinics were paid $1,500 for each methadone slot.

A few critics argued that the claim that methadone would be cheaper was misleading because addicts might require longer treatment in maintenance than in drug-free programs, but their voices were drowned out in the enthusiasm for the new treatment.

"Lifetime costs per [methadone] patient may in fact exceed other modalities with greater short-term costs," Dr. Bertram Brown, then director of the National Institute of Mental Health, testified before Congress in September 1971.

But officials who set up the national drug treatment network thought methadone the most cost-effective approach.

MILLIONS FOR METHADONE

	U.S. Aid	State Aid	Local Aid	Client Fees	Other	Total
1980	$2,234,102	$226,861	$433,497	$610,382	$161,440	$3,666,282
1979	$1,774,000	$357,000	$564,000	$1,465,000	$185,000	$4,345,000
1978	$1,778,000	$170,000	$416,000	$516,000	$112,000	$2,992,000
Total	$5,786,102	$755,861	$1,413,497	$2,591,382	$458,440	$11,005,282

Each year more than $2.5 million in tax money helps pay to treat Florida addicts with methadone. From 1978 through 1980, the state's nine publicly funded clinics got nearly $8 million in tax money. For-profit clinics in Hollywood, Pompano Beach and West Palm Beach, which are not required to report earnings to the government, did not do so in 1978 and 1980. In 1979 the three clinics reported earnings from client fees of $1,096,000.

SOURCE: National Drug Abuse Treatment Utilization Survey

WHAT UNCLE SAM SPENDS

DRUG-FREE RESIDENTIAL

	Slots	Funding per slot	Total spent
1979	12,342	$5,989	$73,852,000
1978	13,731	$5,510	$75,709,000
1977	12,262	$4,319	$53,603,000
1976	14,436	$4,920	$71,073,000

DRUG-FREE OUTPATIENT

	Slots	Funding per slot	Total cost
1979	66,837	$1,554	$103,840,000
1978	73,647	$1,440	$105,840,000
1977	74,383	$1,170	$87,011,000
1976	78,450	$1,170	$91,672,000

METHADONE MAINTENANCE OUTPATIENT

	Slots	Funding per slot	Total cost
1979	40,763	$1,746	$71,169,000
1978	45,541	$1,570	$71,430,000
1977	42,960	$1,512	$62,854,000
1976	44,201	$1,360	$59,928,000

SOURCE: National Drug Abuse Treatment Utilization Survey.

Staff graphics by GALE ENGELKE

The federal government reimburses states as much as 60 percent of the cost of drug abuse treatment based on the so-called "slot funding" concept. Total cost figures for drug-free programs include treatment for all types of drug abuse; methadone maintenance is used only to treat narcotics addiction.

Shaw

Smith

Few reforms are due to panel's 'work'

Congressional committees and agencies have looked into methadone abuse several times in the past 10 years, but few reforms have resulted.

The General Accounting Office has issued three reports critical of the national methadone program, and the House Select Committee on Narcotics Abuse and Control has conducted two hearings on methadone since 1976.

The committee, which has no power to draft legislation, once suggested that methadone regulations be tightened, but the recommendation was disregarded by the bureaucracy.

Following an April 1978 hearing, the select committee staff concluded that "there would be almost no methadone-related deaths" if the drug were not being abused.

The staff criticized lax dispensing practices at clinics and urged the Food and Drug Administration and National Institute on Drug Abuse to tighten restrictions on take-home doses.

FDA and NIDA did not enact the suggested change; instead, the agencies jointly relaxed methadone regulations.

The select committee, which has cost taxpayers $3.3 million, has critics in Congress, but they were unsuccessful in blocking its most recent reauthorization Feb. 8. Congress voted 290-77 to continue the 25-member committee for another two years, at an estimated additional cost of $1.4 million.

The committee is strongly supported by two Broward congressmen who are members — Republican E. Clay Shaw and Democrat Larry Smith.

But other congressmen have criticized the committee as little more than a forum for self-aggrandizement of members, a launching pad for expensive foreign junkets and a swelling and ineffective Capitol bureaucracy.

"The select committee has almost nothing to do with preventing drug abuse, and almost everything to do with congressional excesses: a growing bureaucracy, foreign junkets and shameless self-promotion [of members] that we should all condemn," Rep. Thomas J. Bliley Jr., R-Va., said in the Feb. 8 *Congressional Record*.

"Members did manage to find their way to Italy and Austria at least twice and Germany, Peru and Israel," Bliley stated. He also charged that committee field hearings repeatedly were held in home districts of members, including Fort Lauderdale, at needless cost to taxpayers. He called it "an excellent opportunity for hometown media," but blasted the practice for wasting money.

"We have yet to see any tangible progress [by the committee] in solving the drug problem," argued Rep. Trent Lott, R-Miss., minority whip, also an opponent of reauthorization.

But supporters say the nation's drug abuse problems need as much attention as possible; its members say the committee's function is to coordinate the dozen or so other congressional bodies that have jurisdiction over elements of the drug abuse bureaucracy.

"The committee has heightened awareness of the drug abuse problem. That in itself is enough," Shaw said. "You better believe that is worth the money."

THE LAAM FIASCO

U.S.-backed drug mired in scandal

The federal government has spent more than $25 million during the past 10 years on futile efforts to develop alternative drugs to methadone for the treatment of narcotics addicts.

At least $16 million of that sum was spent on a drug called LAAM, which became mired in two research scandals, bureaucratic ineptitude and the government's own red tape.

And last December — after more than 3,500 patients had received LAAM — the National Institute on Drug Abuse (NIDA) ordered researchers to stop placing patients on LAAM because new tests showed it may cause cancer. Those findings are under review by Food and Drug Administration experts, who must decide whether the threat is serious enough to halt use of the drug.

"The outlook [for LAAM] is not good," said Dr. Harold Ginzburg, associate director of NIDA's Division of Clinical Research.

Asked if LAAM had been a waste of taxpayers' money, he replied: "That's one way to look at it."

Even before the national methadone maintenance program got off the ground, officials began looking for an alternative drug, because they knew they never would be able to prevent abuse of the potent narcotic. They hoped LAAM would be the answer.

LAAM, short for levo-alpha acetylmethadol, is chemically similar to methadone, but its effects last several times longer and it doesn't give users as much "high" or feeling of euphoria. Officials had hoped to dispense LAAM three times a week, greatly reducing the need to give patients doses of drugs to take home.

Many patients on methadone, which must be taken every day, have sold some of their take-home doses to other drug abusers, resulting in a record of overdose deaths that one White House official described in a 1972 memo as being of "scandal proportions."

That official, Dr. Alan Green, a staff member of the Special Action Office for Drug Abuse Prevention (SAODAP), also wrote that "a long-acting substitute methadone-like drug known as LAAM" might be the answer.

But no pharmaceutical manufacturing company shared that enthusiasm. Testing the drug would be expensive and production of a drug to treat narcotics addicts was not expected to yield much profit. The potential for profit also was limited because the formula for LAAM, which was discovered in the 1940s, could not be patented.

So SAODAP officials decided to enter the pharmaceutical business as LAAM's sponsor. It was the first time a federal agency outside the National Cancer Institute had tried to pay for a drug's commercial development.

No one questioned the agency's motive in seeking to develop a drug with the properties of LAAM. But bringing a new drug to market is a complex process that requires extensive testing, first in animals and then in humans, to prove it is safe and effective.

SAODAP and its successor agency, NIDA, "bungled it in a way that only a government agency can do," said Dr. Avram Goldstein, director of the Addiction Research Foundation in Palo Alto, Calif., and a member of the panel now studying the LAAM cancer test results. "The problems with LAAM have been that it was not developed by a pharmaceutical company."

SAODAP awarded a $192,541 contract to Industrial Biotest Associates of Northbrook, Ill., to test LAAM on animals beginning in June 1973. The work was completed in December 1975, and LAAM was pronounced safe.

In June 1975, the government awarded a $3.2 million contract to a company named Medical Research Applications Inc. to conduct human tests and document the results.

A September 1975 White Paper on Drug Abuse, produced by a presidential advisory group, recommended the switch from methadone to LAAM "as soon as the safety and efficacy [of LAAM] have been determined."

Then LAAM's troubles began. In 1976, word leaked out that Industrial Biotest Associates was under investigation for allegedly falsifying results of research on other substances done for the Food and Drug Administration and the Environmental Protection Agency.

The scandal led FDA officials informally to refuse to accept Industrial Biotest's work.

Four officials of the company, including its former president, Dr. Joseph Calandra of Boynton Beach, were indicted in June 1981, each charged with three counts of mail fraud, one count of wire fraud and four counts of submitting false documents to the government. They went on trial April 4 in Chicago; that trial is continuing.

The indictment cited four studies conducted between 1970 and 1976 in which Industrial Biotest stated that a drug or pesticide showed no association with cancer, even though such an association had been demonstrated. Prosecutors in Chicago charge the company falsified research results for financial gain and developed a reputation within the pharmaceutical industry as a company that could be relied on to give any experimental drug a clean bill of health.

The LAAM study, which was conducted from June 1973 through December 1975, is not mentioned in the indictment. NIDA officials audited the LAAM study, and "I believe the results were reliable by and large," said Dr. Mark Snyder, director of the preclinical branch of the National Institute on Drug Abuse. "It was reasonably done. That is not to say that it was perfect."

John Whysner, chief executive of the company conducting the human trials, said he was not so sure then, or now.

"It was a real important safety issue," said Whysner, who claimed

Methadone: The Facts

- The federal government has spent more than $25 million in a futile 10-year search for drugs to replace methadone.
- The drug LAAM, touted as a methadone substitute, was given to more than 3,500 patients before animal tests disclosed it could cause cancer.
- Methadone treatment ends with only one of every 10 addicts who try it free of drugs. Some addicts are able to live a relatively normal life on methadone, but each year more and more become trapped in a closed cycle of addiction, dropping in and out of treatment.
- Illegal methadone, much of which is peddled on the streets by clinic patients given doses to take at home, has been responsible for at least 2,200 deaths nationally; more than 23,000 people have become addicted to non-prescription methadone.
- Most South Florida methadone clinics allow nearly all patients to take home strong doses of methadone — a combination sure to result in illegal diversion. Methadone sold illegally by patients was linked to five overdose deaths in South Florida in 1980 and 1981.
- Methadone was at least a partial cause of 29 drug overdose deaths in South Florida during 1980 and 1981 — twice the number attributed to heroin.
- That death toll includes 15 methadone clinic patients — 10 percent of the reported patient deaths nationwide during those two years. Only 2 percent of the methadone patients nationwide are enrolled in Florida clinics.
- During the past 10 years methadone, alone or in combination with other drugs, has been responsible for the deaths of at least 4,417 people and has sickened at least 24,276 people so badly they required hospital treatment. At least 68 of the fatalities were unborn children of methadone-using mothers.
- The federal government's attempt to protect patients from poor care by the methadone clinics has been slashed to an all-time low.

he urged NIDA officials to repeat the studies before proceeding any further.

"The government people dragged their feet," Whysner said. "They didn't want to spend the money."

Officials eventually did decide to have the animal tests repeated to remove any doubt that LAAM was safe. But EG&G Mason Research Institute, a Worcester, Mass., company paid $664,903 to do the job, didn't start until September 1978, after several thousand addicts had used the drug. The human tests being done by Medical Research Applications were not interrupted by the Industrial Biotest controversy.

In July 1978, before Medical Research completed its work, that contract was criticized by syndicated columnist Jack Anderson as a "sweetheart deal."

The Anderson allegations worried officials at the highest levels of the federal health bureaucracy — including Joseph Califano, then secretary of Health, Education and Welfare. Califano ordered changes in contract procedures and dispatched numerous letters to appease congressmen angered by the allegations.

An audit disputed Anderson's charges of favoritism but raised numerous other questions about Whysner's contract. In September 1979, the government canceled Whysner's contract, a move that ended the large-scale LAAM trial.

That decision left LAAM in limbo. The number of patients using the drug dwindled to about 400, mostly clients at methadone clinics in New York and Los Angeles.

Many LAAM supporters felt the drug had become a victim of Washington politics.

"The poor drug has been unfairly maligned over the years," said Dr. Charles O'Brien, director of the psychiatry service at the Veterans Administration Hospital in Philadelphia.

Late last year, the second round of LAAM animal tests ended with a warning that the drug may cause liver cancer in laboratory rats.

EG&G Mason tested both LAAM and methadone. Though methadone showed no apparent association with cancer, LAAM produced "statistically significant increases" in cancers in the test animals, according to government records.

On Oct. 18, NIDA Director Dr. William Pollin sent letters to researchers using the drug. Pollin's letter stated that the animal studies "indicate that rats have a greater than anticipated" rate of tumors.

Eight weeks later Pollin sent another, far more ominous letter.

"No further patients shall be inducted on LAAM until an evaluation of its potential carcinogenicity and therapeutic risk-ratio is made," the Dec. 13 letter reads.

Researchers were ordered to make sure that patients remaining on the drug signed a form certifying that the patient had "discussed the possibility that LAAM may be a carcinogen with my clinician," but had decided to remain on the drug rather than return to methadone.

Many patients were not interested in waiting for the final word. Dr. Arnold Washton, who distributes the drug to about 50 patients at New York Medical College, said about 20 percent of his patients dropped out when told of the cancer risk.

Yet panelists interviewed by the *News* and *Sun-Sentinel* said they emerged from a March 16 discussion concluding that there was no reason to suspect increased cancer risk in humans.

"It was my opinion and the group's that the risk in humans couldn't be determined based on the animal studies," said Dr. Rob-

U.S. Health, Education and Welfare Secretary Joseph Califano, worried by allegations that one LAAM testing contract was a "sweetheart deal," ordered changes in contract procedures and wrote numerous letters to appease angry congressmen.

ert Squire, a Johns Hopkins University animal-pathology expert.

The cancer controversy has placed LAAM's fate in the hands of FDA officials, who have yet to decide what to do.

Dr. Edward Tocus, who heads the FDA's drug abuse section, noted that the agency might approve continued use of LAAM if officials conclude its benefits outweigh any health risks.

If LAAM survives the cancer-study findings, all existing data on the drug must be collected into a formal document called a New Drug Application for FDA review. Ginzburg said NIDA legally cannot take this final step, but must find a commercial sponsor for LAAM.

Officials disagree on the cost of preparing that document, largely because of uncertainty about whether any testing needs to be repeated. Ginzburg estimated the cost at "several hundred thousand dollars," but a 1980 NIDA report stated the cost could reach $3 million.

NIDA officials never have added up the tax dollars spent on LAAM; after numerous written and oral requests by the *News* and *Sun-Sentinel* over the past three months, the agency produced a partial listing of LAAM contracts that showed a price tag of at least $16 million.

NIDA officials had hoped that the passage in February of the Orphan Drug Act might save the government some money. That law is designed to speed marketing of drugs which cannot find a sponsor because they would be used by fewer than 200,000 people, and thus not return large profits to a pharmaceutical manufacturer.

But FDA has taken the position that LAAM has a sponsor — the National Institute on Drug Abuse. As far as the FDA is concerned, that leaves LAAM ineligible for special consideration.

"This is a perfect Catch-22," Ginzburg said.

U.S. paid for research, then for data

Federal officials paid a researcher $3.5 million to develop information on the use of LAAM in treating heroin addicts, then had to pay him $200,000 more to get their hands on the data they had paid him to collect.

It was John Whysner's first try at the drug business; it also was his last.

When the National Institute on Drug Abuse was created in 1975, Whysner — a former pediatrician and consultant to the Nixon White House drug abuse program — quickly became a "major" NIDA contractor, according to government records.

In 1975, NIDA officials concluded that the only way to market LAAM as an alternative to methadone would be to pay someone to test it. The agency gave John A. Whysner Associates a contract to arrange for tests of the drug in humans to be conducted and documented.

The contract also gave Whysner exclusive rights to the data collected at taxpayers' expense, data which were needed to win approval to market the drug. At the time, the government had no written guidelines for determining the terms of such an unusual contract.

"The fact that I got the data was an incentive in the contract," said Whysner, who now lives in New York. He denied impropriety and said his company became the victim of "politics and journalism."

In 1978, before Whysner's tests were completed, syndicated columnist Jack Anderson criticized the LAAM contract. Anderson reported that Whysner had an "inside track" on the "plum" contract because of his former government work.

Anderson's allegation that favoritism had influenced the award later was disputed by an audit conducted by the Inspector General's office of the Department of Health, Education and Welfare (now Health and Human Services).

Whysner had "no experience with the complexities of the Food and Drug Administration's requirements for obtaining approval to market a new drug," according to the audit.

Though auditors concluded that Whysner's was not considered the "most qualified" company to handle the tests, they also stated that his company got the contract after 40 other companies and university researchers turned it down.

But the audit disclosed other "serious problems" with the LAAM contract that had not been subjected to public scrutiny.

Nine months after receiving the contract, Whysner was granted blanket immunity from lawsuits that might arise from the tests. He had told officials he was unable to get insurance.

The auditors pointed out that more-qualified companies had balked at the proposal largely because the government had refused to indemnify them.

The contract also granted Whysner exclusive rights to sell the drug once it was approved. The government, which expected to be LAAM's biggest customer, never bothered to negotiate a price.

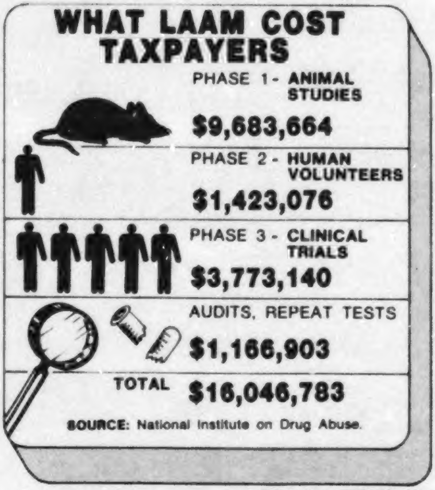
Auditors also criticized the contract's "cost sharing terms." Because Whysner would reap all profits from the drug, the government's goal was to compel Whysner to assume half the cost of testing it. But Whysner ended up paying only $46,784, less than 2 percent of the $3,573,140 total cost, according to government records.

Whysner never completed the LAAM studies, but not because NIDA officials believed that his work had been inadequate. The contract was terminated Sept. 11, 1979 — "at the convenience of the government," largely because of the uproar over Anderson's allegations.

Whysner said his business, which he had renamed Medical Research Applications Inc., was ruined as a result. He saw red when the government demanded that he return the data.

On June 5, 1981, almost two years after the contract was canceled, the government gave Whysner his final payment, $332,445. NIDA records euphemistically call $200,000 of that payment — the amount in excess of the original contract — "termination costs."

In fact, that payment was to secure boxes of study data, which remain in storage at NIDA's headquarters in Rockville, Md.



SOURCE: National Institute on Drug Abuse.

Staff graphic by KEITH ROBINSON

Estimated spending on LAAM includes only contracts funded by the National Institute on Drug Abuse after 1975. Officials were unable to locate earlier records. NIDA's predecessor, a special White House office, spent at least $550,000 on LAAM in 1972 alone, according to documents obtained by the *News* and *Sun-Sentinel* from the National Archives.

Even backers have to admit LAAM's limits

Some government officials worried they might be throwing good money after bad if they continued to finance tests on LAAM, a methadone derivative plagued by scandal and government bungling.

So in August 1980, Dr. William Pollin, director of the National Institute on Drug Abuse, convened an eight-member advisory panel to resolve the controversy.

Two of the eight members previously had received NIDA grants to test LAAM; two others were ardent supporters of the drug.

Their report raised as many questions as it answered. Highlights of the report, obtained by the *Fort Lauderdale News* and *Sun-Sentinel* through the Freedom of Information Act:

- The panel members recommended NIDA continue the LAAM project, but not as a replacement for methadone — the original intent of the drug.
- Estimates of the drug's potential users vary from 25 percent to 75 percent of the nation's male methadone patients. Women, who make up 31 percent of methadone users, are ineligible because the drug's effects on the reproductive system have not been determined. At best the market for LAAM would be 37,122 people; at worst it would be 12,374, using the latest available government figures.
- Acceptance of LAAM would increase if patients could not get methadone, which produces more euphoria. But panel members recommended against trying to replace methadone with LAAM.
- The LAAM project could cost taxpayers an additional $3 million, on top of the more than $16 million already spent on the drug, mostly

to repeat some tests which may have been conducted improperly or may be incomplete.

- NIDA spent more than $500,000 and a "couple of years of staff [time]" to audit LAAM animal studies conducted by a company embroiled in allegations of research fraud. NIDA hoped the audit results would convince Food and Drug Administration that the LAAM tests were conducted properly. FDA refused to accept the audit and the tests had to be repeated, at an additional cost of more than $600,000.

Despite the uncertainties about LAAM, members of the 1980 panel were convinced the drug had proved its worth and should not be "sacrificed" to permit the agency to spend limited research dollars on alternative drugs.

Panel members insisted LAAM would reduce black-market methadone sales and "unnecessary deaths," both caused because methadone often is dispensed to patients to take home. Officials claim LAAM, which is administered three times weekly, would not be given to take home.

The panel also concluded that fewer visits would reduce operating costs, which in turn would improve treatment. Limited funds have "made it more difficult for programs to provide adequate counseling and rehabilitation services," the report said. Fewer clinic visits also would reduce the number of people who loiter near clinics and thus "inflame neighborhoods."

Panel members said they were "disturbed" by questions about the quality of the LAAM data.

Records of about one-third of the 3,500 humans studied by primary LAAM contractor John A. Whysner had not been analyzed. As a result, the report stated that members "could not be absolutely sure there were no surprises in that part of the data."

No decision on LAAM's future resulted from the study report. The project has languished; most recently it has become the responsibility of the NIDA Addiction Research Center in Baltimore.

"The government has a lot invested in LAAM. We don't like to see it not come to fruition," said Dr. Jack Scanlon, ARC director.

Early tests hinted drug would fail

Staffers at two South Florida methadone clinics chosen to test LAAM found the drug was a bust.

Only two of 42 patients completed a 40-week test of the drug at Broward Methadone Maintenance Rehabilitation and Research Facility in Hollywood. At Miami's St. Luke's Center, all but 14 of 88 LAAM study patients dropped out, according to federal records.

Most patients quit outright: 15 at the Hollywood clinic cited side effects such as nausea, dizziness and vomiting, and at St. Luke's, the most common reasons for termination were depression, impotence and insomnia.

But the real reason most patients rejected LAAM, researchers later concluded, was that the long-acting drug failed to produce as intense a "high" as methadone.

"The addict is looking for a little buzz, for narcotic warmth; when they don't get it they think they are sick," said Dr. Arnold Washton, director of the Division of Drug Abuse Research and Treatment at New York Medical College.

"LAAM can't compete with methadone," said Washton, who runs the largest remaining LAAM-dispensing clinic, with about 50 patients. "That is a misguided notion."

Government officials proceeded with LAAM tests despite evidence that most addicts spurned the drug. They also disregarded studies suggesting that the drug could be dangerous.

LAAM was tested on more than 3,500 patients between 1973 and 1979; 60 to 69 percent of patients failed to complete the studies, compared to dropout rates for methadone patients ranging from 40 to 48 percent.

In September 1975, about six months after the first large-scale human trial was completed, a White House task force recommended switching from methadone to LAAM. National Institute on Drug Abuse officials in July 1976 were more reserved; a scantly circulated policy statement noted the agency "does not currently anticipate that LAAM implementation will lead to dramatic alteration of the current federal opiate addiction treatment or philosophy."

In April 1978, however, representatives of the Carter administration vowed to push for "accelerated development" of LAAM. In their testimony before a congressional committee investigating methadone deaths, Carter aides made no mention of LAAM's drawbacks.

But warnings were appearing in some medical journals. Perhaps most worrisome: LAAM's lack of euphoria made the drug potentially dangerous.

Dr. Jack Blaine, a research psychiatrist who supervised the LAAM experiments for NIDA, conceded that some patients injured themselves by mixing LAAM with other drugs because they could feel no "high" from LAAM.

Of the 3,594 addicts given LAAM through 1979, 21 died. Published research findings didn't disclose what caused all the deaths, but one study attributed nine of 17 deaths examined to "lethal mixed drug overdose" of LAAM and other drugs, most commonly alcohol and the sedative diazepam.

Blaine's research team concluded in 1980 that LAAM patients "at first glance appear more vulnerable to mixed drug overdose than methadone patients." They stated, however, that this conclusion could not be drawn with certainty because the government never had tried to determine how many patients died after mixing methadone with other substances.

Dr. Jerome Jaffe, who headed the Illinois Drug Abuse Program, was one of the first researchers to use LAAM as a substitute for methadone. His 1970 research, financed by the U.S. Public Health Service, indicated that, in general, LAAM could be substituted for methadone. Researchers noted, however, that dropout rates appeared slightly higher with LAAM, and that the drug's "delayed onset" (at least four hours) and "sustained action" (effects last at least 48 hours) "may also be the basis for difficulties."

Jaffe, who would be appointed President Nixon's top drug abuse adviser in June 1971, wrote:

"If an occasional individual does attempt to abuse the drug, unaware of this delayed onset, he may administer a number of doses thinking that the drug is merely 'weak' or 'diluted.' By the time the effects appear he may have already self-administered a lethal overdose."

Jaffe, now a professor at the University of Connecticut School of Medicine, said in a telephone interview that it was "ironic" that few addicts would take LAAM. But he said most patients dropped out because they were given the option of returning to methadone. In 1971 Jaffe said LAAM's "potential problems are not insurmountable," because "clinicians can be educated to be alert to the possibility" of LAAM overdoses. He added: "Whether it will be as easy to teach patients about these unusual effects is not certain."

Naltrexone: 'Not a major step forward'

The federal government has spent at least $9 million to develop a drug called naltrexone to treat addicts — even though few experts ever believed it would do much good.

Naltrexone negates the "high" an addict gets from heroin; scientists call it an opiate antagonist. The theory of naltrexone is similar to the theory of Antabuse, which is used for treating alcoholics: with Antabuse an alcoholic who drinks gets ill; with naltrexone, an addict who uses heroin feels no euphoria.

The reason the two drugs have been used infrequently over the years is similar as well: They work only when patients take their medicine regularly.

Few do.

"Naltrexone is not a major step forward. It's a pity," said Dr. Leo Hollister, of the Veterans Administration Hospital in Palo Alto, Calif., who directed one of the government's first studies of the drug in 1973. He still supports efforts to market it, even though he admits, "It is not the big answer that people hoped it would be."

The investment in naltrexone was spurred by congressmen concerned about the government's endorsement of treatment using an addictive drug, such as methadone.

One of the most influential supporters of antagonist therapy was former Rep. Paul Rogers, D-West Palm Beach, then chairman of the powerful subcommittee on Health and the Environment.

Rogers feared that methadone simply would spread addiction, rather than encouraging addicts to free themselves from drugs.

"The Nixon people weren't that interested in research on an antagonist," Rogers recalled. "The push came from Congress. We kept pounding on them."

The Drug Abuse Office and Treatment Act, which became law in March 1972, reflects that pressure. The law requires research into drugs such as naltrexone.

But good intentions could not overcome practical problems.

In 1966 Dr. Jerome Jaffe, who studied an antagonist while head of Illinois drug programs, published research noting that patients complained of unpleasant side effects, dropout rates were enormous, relapse rates were very high, and daily distribution of the drug was impractical.

Jaffe, who eventually became President Nixon's chief drug abuse adviser, believed that many of these drawbacks could be overcome, but he also admitted: "Despite their great theoretical promise, antagonists might prove to be of value only to a limited subgroup" of addicts.

In 1967, Endo Laboratories, a division of DuPont, patented a new antagonist, naltrexone. The drug produced few unpleasant reactions and its effects lasted several days.

Fearing that low profit potential would prevent DuPont from conducting pre-market research on the drug, federal officials agreed to finance the tests.

Between 1973 and 1974, the government spent $5 million on naltrexone research. In September 1978, Endo received a five-year, $4 million contract to conduct clinical trials in humans. That work is scheduled to be completed in December; Endo will retain the exclusive right to sell the drug.

NIDA officials were unable to provide the costs of numerous other government-sponsored naltrexone trials.

Naltrexone may have been an improvement over its predecessors, but the drug's inability to replace methadone was apparent, principally because it offers no euphoria.

By 1976, numerous scientists were suggesting that the drug never would live up to expectations. One researcher whose work was financed by NIDA called it "a drug in search of an audience;" another dubbed it "a good drug

File photo

Former Rep. Paul Rogers, at left, with President Nixon in 1971. "The Nixon people weren't that interested in . . . an antagonist," Rogers recalled. "The push came from Congress."

that we can't give away.'

Now most experts say the drug might help select groups of addicted doctors, nurses and other professionals — those highly motivated to kick their habits. Others are studying whether naltrexone can be used alongside methadone to wean addicts from heroin.

Ironically, naltrexone's major use in the future may have little to do with drug abusers. Narcotics antagonists are beginning to show promise for use in treating victims of shock.

Should naltrexone ever be used for that purpose, Endo would reap any profits even though taxpayers financed the drug's early development. The company probably would not be asked to repay any testing costs.

NIDA official Marvin Snyder said his agency's contract with Endo makes no mention of any other uses for the drug.

FDA officials confirmed they have received a formal request to market naltrexone, but would not say when a decision will be reached.

Non-addicting opiate has 'own set of problems'

The government's latest hope for an alternative drug to replace methadone is an experimental, non-addicting opiate drug.

But buprenorphine — a painkiller National Institute on Drug Abuse researchers are touting as a major breakthough for treating addicts — has gotten a cooler reception in other quarters.

"This is not a panacea, but it is better than anything we know of," said Dr. Donald Jasinski, scientific director of the NIDA's Addiction Research Center in Baltimore. "It is a significant advance."

Buprenorphine was developed by British chemists. It is marketed in a number of countries overseas, but has yet to win Food and Drug Administration approval for use in the United States.

Jasinski is convinced buprenorphine could be substituted for methadone and would be much safer for patients and the public. Others are not so sure, and NIDA has not decided whether to proceed with developing the drug for addiction treatment.

"People here feel that this is a pretty good drug, that it might supplant methadone, but only time will tell," said Dr. Jack Scanlon, director of the research institute.

Yet a NIDA-convened study panel in late 1980 concluded that buprenorphine had its "own set of problems," some of which even avid boosters like Jasinski admit need study.

The drug produces euphoria, which might make it a mixed blessing for treatment personnel. The seven-member study panel stated: "Its euphoric effect, while helpful in keeping patients in treatment, may create problems such as abuse potential and possible interference with rehabilitation and regular employment or education."

But other properties appear to give the drug great promise. Because buprenorphine does not produce a high degree of physical dependence, treatment could be discontinued with little discomfort to the patient. And unlike other narcotics, the drug causes little depression in breathing, thus making overdose death unlikely, no matter how large a dose is taken.

Jasinski conceded that the drug has not been tested outside highly controlled conditions. He also conceded that he "suspects" that some patients given buprenorphine would try to boost the drug's euphoria by combining it with other substances, and might injure themselves.

"All drugs have to be an adjunct to treatment. If anybody thinks there is a magic bullet, that is foolish," he said.

Buprenorphine must clear numerous hurdles before it can be used to treat addicts. The application awaiting FDA approval would permit use of the drug only as a short-term painkiller.

FDA most probably would require long-term animal studies before permitting the drug to be taken for years by patients. Those tests could take as long as eight years and cost as much as $10 million.

If the manufacturer balks at paying for the tests, the government would face another question: whether to jump into the pharmaceutical business as it has done with LAAM, either by conducting the tests or paying a private company to do them.

"I doubt if the federal government would ever undertake the LAAM experience again. That was started under rather desperate circumstances," Scanlon said. "We [the government] are not a drug company."

Clonidine helps ease pain of withdrawal

A drug now widely used to treat high blood pressure may help addicts kick the methadone habit.

The drug clonidine appears to curb the flu-like withdrawal symptoms addicts suffer when deprived of narcotics; it is the only non-narcotic drug having that property.

Many methadone patients claim they remain on the drug because they fear they won't be able to complete a "detox" — gradual reduction in methadone doses during a three-week period.

"Every cell in your body aches for opiates," said one former South Florida methadone patient who completed the process.

Specialists agree that those accustomed to large methadone doses, as are commonly given in South Florida clinics, face withdrawal symptoms when they are weaned from the drug.

Most never complete the 21-day detox treatment, whether it is accomplished in a hospital charging thousands of dollars, or in a government-funded outpatient clinic. In either setting, only about one in five patients succeeds in becoming drug-free, according to government records.

In fact, officials of the National Institute on Drug Abuse have been criticized by government auditors for continuing to pay for detox treatments in the face of government-sponsored studies showing the procedure seldom works. NIDA officials estimated that $5.8 million in tax money was spent during 1978 to detoxify about 30,000 heroin addicts.

Clonidine might change things.

Some doctors are using clonidine during detox, but the procedure remains experimental because the Food and Drug Administration has yet to approve the drug's use for opiate detoxification.

Dr. Herbert Kleber, professor of psychiatry at the Yale University School of Medicine and director of the Substance Abuse Treatment Unit at Connecticut Mental Health Center, in New Haven, has used the drug on about 500 addicts and is enthusiastic.

Kleber said clonidine given during a 10-day period reduces withdrawal symptoms and "gets people through [detox] better." He thinks that in the future clonidine will be one of several drugs used to help addicts in withdrawal.

According to Kleber, the "ideal solution" might be to give addicts two years of methadone maintenance, then proceed with detoxification. He hopes that a third drug, naltrexone, which blocks the euphoria an addict receives from narcotics, might help addicts remain free of drugs.

Patients often insist they are anxious to get off methadone, but many clinic workers doubt their sincerity.

"On methadone I can hold a job and I act normal, but I can't get off the stuff," said one female South Florida patient. "There are a lot of junkies out there who don't want to get on the methadone for that reason."

Many methadone clinics discourage patients from trying to detox, insisting they will fail and be "back on the street."

Florida methadone clinics reported to the federal government that only 16 patients were undergoing detoxification as of Dec. 31, 1981, a time when 1,869 were receiving methadone maintenance.

"Drug-free is not a realistic goal for most of these people," said Dr. Edward Senay, a psychiatry professor at the University of Chicago. "Heroin addiction tends to be a chronic disease, so that the only real question is whether the narcotics they take are legal or illegal."

THE MYSTERY OF ADDICTION

Progress is slow, outlook uncertain for addiction cure

> "Our [drug abuse treatment] *programs cannot be judged on the fulfillment of quotas and other bureaucratic indexes of accomplishment. They must be judged by the number of human beings who are brought out of the hell of addiction."*
>
> **— President Richard Nixon in a message to Congress, June 17, 1971.**

Nothing authorities did persuaded "John" to quit shooting heroin for long. He was thrown into jail; he was detoxified with methadone; he was forced to live in group homes where he was pressured to forsake drugs.

"Most addicts resent treatment programs from the start," said the Miamian, who prefers to use a pseudonym when discussing his past. "They are only there because of a judge, their families or because they are going to lose their job."

John said he stopped using heroin because he grew "disgusted" with the life he was leading, and resolved to change things.

"It took a long time for me to surrender to the fact that I can't use drugs," said John, who has remained abstinent for many years.

Each year, more than 100,000 opiate addicts enter federally funded treatment programs — methadone clinics, group homes called "therapeutic communities," or outpatient counseling centers — which cost taxpayers hundreds of millions of dollars a year.

But few find help in any treatment, according to statistics reported to the federal government:

● More than half never complete treatment.

● Only about one in eight is discharged free of drug use.

● Though 13.8 percent of patients got a job while in treatment, almost as many — 13 percent — had a job but lost it while in treatment.

● Fewer than 3 percent completed job training, and only 6 percent were enrolled in an educational program at discharge.

"There is no question that quitting is the most common form of termination from drug treatment," said Dr. Saul B. Sells, of Texas Christian University, which has been paid by the National Institute on Drug Abuse to evaluate agency-funded drug treatment programs. NIDA stopped collecting discharge statistics in 1981 because of budget reductions.

Methadone: The facts

- Methadone is not the only "cure" for narcotics addiction that has been less than completely successful: Residential facilities and outpatient counseling centers that stress abstinence from drugs also fail to rid most of their patients of drug use.
- Despite billions of tax dollars spent on treatment and research, science has not been able to determine whether the cause of narcotics addiction is physiological or psychological — and scientists expect no breakthroughs soon.
- The federal drug abuse treatment bureaucracy has been subsidizing treatment clinics for a decade even though officials have not known what services many of the clinics were providing.
- The federal government has spent more than $25 million in a futile 10-year search for drugs to replace methadone. One of those drugs was given to more than 3,500 patients before tests disclosed it could cause cancer.
- Methadone treatment ends with only one of every 10 addicts who try it free of drugs. Some addicts are able to live a relatively normal life on methadone, but each year more and more become trapped in a closed cycle of addiction, dropping in and out of treatment and alternating between street drugs and clinic methadone.
- Illegal methadone, much of which is peddled on the streets by clinic patients given doses to take at home, has been responsible for at least 2,200 deaths nationally; more than 23,000 people have become addicted to non-prescription methadone.
- Most of South Florida's methadone clinics allow nearly all patients to take home strong doses of methadone — a combination sure to result in illegal diversion. Methadone sold illegally by clinic patients was linked to five drug overdose deaths in South Florida in 1980 and 1981.
- That death toll includes 15 methadone clinic patients — 10 percent of reported fatalities nationwide during those two years. Only 2 percent of methadone patients nationwide are enrolled in Florida clinics.
- More than 40 percent of methadone patients in Florida are treated by profit-making clinics. Nationwide, for-profit clinics treat only 7 percent of the patients.
- During the past 10 years methadone, alone or in combination with other drugs, has been responsible for the deaths of at least 4,417 people and has sickened at least 24,276 people so badly they required hospital treatment. At least 68 of the fatalities were unborn children carried by methadone-using mothers.
- The federal agencies that sanctioned the drug's use and supervised its distribution through tax-subsidized clinics have collected masses of information about the methadone program but never have analyzed the data to assess the treatment.
- The federal government exempted methadone from legally required studies of its long-term effects on health, even though the proposed maintenance therapy could result in a patient taking the drug for years.

The *Fort Lauderdale News* and *Sun-Sentinel* found that the percentage of drug-free discharges has been declining, and that the number of people who drop out or are discharged for disciplinary reasons is increasing. At the same time, an ever-growing number of narcotics addicts also are misusing other drugs, complicating their treatment.

While many addicts like John eventually become drug-free, nobody knows what role formal treatment programs play in the process. And scientists concede they are years away from understanding how social, physical and environmental factors intertwine to foster drug addiction.

"Opiate addiction treatment is very frustrating. We are not making wonderful progress," said Dr. Leo Hollister, a psychiatrist at the Veterans Administration Hospital in Palo Alto, Calif.

The federal government, through a variety of agencies, has spent an estimated $2 billion on many different drug treatment programs in the past decade; officials insist that all types of treatment have proved effective.

These officials object to the use of discharge statistics to measure effectiveness of drug treatment programs. Most cite a study by Sells which reported that about one-third of 1,477 addicts admitted to treatment were drug-free five years after release. In the same study, about one-third showed no measurable reduction in drug use or got worse, and the remainder fell somewhere in between.

But government officials concede that factors other than drug abuse treatment may have influenced those outcomes.

For example, 40 percent of the study subjects spent some time in jail in the interim, which could have persuaded them to stop using drugs. The study also found that 60 percent of the patients had at least one additional admission in the interim, and that 43 percent returned to daily heroin use at some point in the period.

Many treatment specialists interviewed by the *News* and *Sun-Sentinel* were less defensive than the bureaucrats. Treatment programs don't work for everybody, particularly those forced into therapy, the specialists said.

"If anyone tells you he has an across-the-board success rate in treating drug addicts, he is lying," said Dr. Delores Morgan, director of the addiction treatment program at South Miami Hospital.

Jody Rosen, program director for Spectrum of Broward, a residential drug-free program in Wilton Manors in which half the patients are enrolled through the courts, added: "I used to get discouraged because I thought we could help everybody. That is unrealistic. The therapist is only as good as the client allows him to be and some of these people don't want to change."

Rosen, a recovered heroin addict from a "middle class" background, said drug abusers start and stop using drugs at their own pace.

"Some of my friends started using heroin and I thought they were the lowest thing on earth. Then I experimented with it, and I loved it," said Rosen, who was 17 at the time. "Heroin was so powerful and exciting. These people didn't look so disgusting anymore."

While Rosen, now 35, said he had periods of self-imposed abstinence, he spent the better part of 10 years dominated by heroin. "I tried to get out of this, but I liked being irresponsible. I don't understand this myself."

Rosen's experience is not uncommon:

He enrolled in a methadone program to reduce the size of his habit, then dropped out, feeling more "helpless" on methadone than on the street.

An arrest for selling heroin sent him to a drug-free program in Miami; he dropped out and returned to his old ways.

After he was arrested again for his role in a ring that forged prescriptions for dilaudid, a narcotic addicts use in South Florida, he was ready to change.

"I was at the bottom of the barrel — really scared," Rosen said. "I figured I would either die or be an addict for the rest of my life. This time the treatment worked." Rosen has been employed by the program ever since.

Others involved in treating addicts believe that expectations for drug treatment programs were too high in the beginning.

Dr. Jerome Jaffe, the first director of President Nixon's Special Action Office for Drug Abuse Prevention, which began funding the programs in 1973, called the results "remarkable."

"At the time that we set up these programs there was a view that once an addict, always an addict," said Jaffe, now a psychiatry professor at the University of Connecticut School of Medicine.

"When you look at [drug addiction] in a realistic sense it is one of a whole lot of chronic diseases, like arthritis. Nobody expects us to cure these other illnesses that may be recurring," he said.

But Jaffe acknowledged that drug abuse treatment programs are not like most medical initiatives, which patients seek voluntarily. Drug abuse treatment is often forced upon an addict.

"I don't think there ever was a notion that treatment was set up to do some-

ADDICTION: THE UNSOLVED AILMENT

Science has not been able to solve the problem of narcotics addiction. Despite staggering sums of tax money spent on a variety of research and clinical programs across the country, only one of every eight addicts discharged from treatment in 1981 — the latest year for which statistics are available — wound up free of drugs. And instead of getting better, we're getting worse: 1981's record was the worst in five years. Chart shows percentage of patients discharged from the major types of treatment after ridding themselves of drug use.

	Drug-Free Outpatient	Drug-Free Residential	Drug-Free Hospital	Methadone Maintenance	Detoxification Outpatient	Detoxification Hospital	All Patients
1981	13.2	8.3	26.6	9.3	15.9	20.3	12.5
1980	14.7	8.2	18.9	11.7	21.5	20.7	15.2
1979	14.9	9.4	14.3	14.0	16.7	16.5	14.6
1978	14.5	10.0	13.3	12.3	11.0	11.1	12.9
1977	13.0	11.4	16.3	11.0	15.3	14.2	13.0

SOURCE: Client-Oriented Data Acquisition Process, National Institute on Drug Abuse.

GLOSSARY:

Drug-free: Uses no chemical agents except possibly temporary use of tranquilizers for psychiatric problems. Primary treatment method is traditional counseling.

Maintenance: Continued administration of drug to achieve stabilization, then gradual methadone withdrawal, detoxification and abstinence.

Detoxification: Planned withdrawal of a patient from a drug, generally in three weeks or less.

Outpatient: Patient makes regular visits to a treatment center for therapy, counseling and supportive services.

Residential: Patient lives at the treatment center while undergoing therapy.

Hospital: Treatment is administered in a hospital where patient also may receive care for medical or psychiatric problems.

Staff graphic by GALE ENGELKE

thing good for junkies," Jaffe said in a telephone interview. "There is no question that it was to benefit society. As a taxpayer, I would find a long list of others more deserving than addicts."

Jaffe, who ran Illinois drug programs before joining the White House staff in June 1971, said he hoped to decrease "predatory behavior" by addicts who turned to crime to support their habits.

But Dr. Bertram Brown, who served as director of the National Institute of Mental Health (NIMH) during the Nixon administration, believes drug abusers became victims of this philosophy. He criticized Nixon aides for having the "audacity" to twist a medical treatment into a "political priority."

"That is the lesson to be learned. Medicine should not be run out of the White House. These people knew no limit," said Brown, now president of Hahnemann University, a medical school in Philadelphia. "People were forced into treatment. What if these had been cancer victims?"

Brown, who angered Nixon aides by criticizing methadone maintenance, argued that addicts should be given a choice in their treatment. However, the programs operated by NIMH before the Nixon administration also were involuntary for the most part. And the prison-like U.S. Public Health Service hospitals in Lexington, Ky., and Fort Worth, Texas, as well as community-based programs, had recidivism or dropout rates as high as 80 percent, according to NIDA officials.

While the effects of political pressures on drug abuse treatment remain hazy, there is little doubt that rifts within the field have hampered program development.

Many advocates of drug-free treatment are openly contemptuous of methadone, which they regard as simply substituting one addiction for another. But in most cases, these critics are unable to demonstrate that their programs are more effective in leading to drug abstinence.

"Sure, patients would be better off if there were less infighting," said Richard Harrington, who directs Dade County's drug abuse treatment system.

Some of the rivalry has abated in recent years. But federal budget reductions once again are forcing programs to compete with each other to stay alive.

Methadone maintenance pioneer Vincent Dole, who believes the technique has failed to live up to expectations, is angered by what he sees as attempts by poorly operated drug-free programs to discredit methadone.

"Whatever faults you find with methadone, it is vastly better than the alternatives. Even the poor [methadone] programs are giving people a chance," said Dole, senior physician at Rockefeller University in New York City.

"The people who benefit from knocking methadone are those who run unsuccessful drug-free programs," he said.

While experts debate which treatment approach produces the most successes, their patients are getting more difficult to treat — largely because they are consuming more drugs. Patients with dual addictions, such as a narcotic and a tranquilizer, sometimes need concurrent treatment programs to break their habits.

Government documents obtained by the *News* and *Sun-Sentinel* disclose that multiple drug abuse by patients admitted into government-funded treatment programs has been increasing steadily since 1977.

In 1977, 48.7 percent of patients listed a secondary drug in addition to heroin, and 23.5 percent listed a third drug, according to NIDA statistics. During 1981, 55.6 percent listed a second drug and 25.5 percent listed a third.

Big-city hospital emergency rooms and medical examiners also have reported finding that heroin and methadone increasingly are being combined with other drugs, according to Drug Enforcement Administration records.

In 1974, 23 percent of those treated by emergency rooms in 26 urban areas for heroin-related ailments also had taken another drug. By 1981, that figure reached 41 percent. Similar increases were reported with methadone.

Drug overdose deaths also show a trend toward combinations of drugs. Medical examiners in the 26 urban areas reported that in 1974, 61 percent of deaths linked to heroin also involved other drugs. By 1981, that figure jumped to 81 percent. Methadone-related deaths involved other drugs in slightly higher proportions than heroin in the mid-1970s, but in recent years the rate has been identical to heroin.

Staffers at South Florida drug treatment programs said they are seeing more patients who combine drugs.

Steve Leibowitz, a counselor at Miami's Central Methadone Facility recalls questioning a patient whose urine had been found to contain traces of cocaine. The patient was angered when told that his use of cocaine had to stop.

"This guy said he was being treated for heroin addiction here, and what other drugs he did was his own business," Leibowitz said. "I told him it didn't work that way."

That attitude is the latest challenge for drug treatment. Some treatment specialists are fearful that overdose deaths will soar unless these trends are curbed.

"These poly-drug people are more screwed up than heroin addicts," said Spectrum's Rosen. "A heroin addict can function, but these other people can't even stand up, let alone hold down a job. They are out of control."

Audits: Agency slow to revise clinic methods

Though the federal government has been subsidizing drug abuse treatment programs for a decade, officials still don't know what services many of the tax-funded clinics offer.

So officials of the National Institute on Drug Abuse are spending $4.5 million to ask clinics and their patients. The Treatment Outcome Prospective Study (TOPS) will determine "what the treatment process is," one official said.

"TOPS will help us understand what happens to the client, such as to what extent counseling is being provided by a sample of programs," said Barry Brown, acting director of the NIDA Division of Clinical Research.

NIDA expects to begin publishing results of the study, which began in 1979, by next spring. The study also is supposed to set "reasonable expectations" for treatment programs.

But the TOPS study may not resolve some of the thorniest questions about drug abuse treatment — such as which type of treatment is most effective.

"We don't know whether the data will find differences between who does and does not do well," said Brown, adding: "TOPS may resolve some controversies and stir others up."

That sort of explanation has failed to satisfy some critics, who argue that NIDA has been slow to seek answers that would help field workers improve the quality of treatment programs.

NIDA has been criticized in several reviews conducted by the Inspector General's office of the federal Department of Health and Human Services, and the General Accounting Office, the investigatory arm of Congress.

Among the criticisms:

● Performance standards that clinics must meet to keep federal funding have been vague or meaningless. It took nine years to tighten these standards by setting up a procedure to identify "substandard clinics."

● Reimbursement methods have encouraged clinics to reduce services instead of improve them. Millions are spent on ineffective treatment methods, and some patients are enrolled even though they are not heavy drug abusers.

● Standards for training and education of drug abuse workers, recommended in 1975 by the Joint Commission on Accreditation of Hospitals, have yet to be adopted even though many experts believe such standards would improve the quality of treatment.

The HHS Inspector General's office was particularly disturbed to discover that a management company hired by NIDA had found that many clients were admitted to treatment for marijuana abuse even though they did not use the drug often or heavily enough to keep them from functioning normally.

That report was completed in 1979. In April 1980, GAO issued a report urging that NIDA take a hard look at some of the treatment programs it was paying for.

NIDA officials note that many treatment programs are pressured by the courts to admit patients as an alternative to jail, even if their drug abuse is not serious enough to warrant treatment.

NIDA officials also insist that many problems they face are difficult to resolve. For example, NIDA officials resist efforts to force choices between methadone and drug-free programs, preferring to let patients make that decision.

Treatment programs such as outpatient detoxification, a system that government studies show seldom works, are continued because of pressure from within the field to have a mechanism for weaning patients from methadone.

Credentialing standards also present a dilemma. Traditionally, many drug abuse workers are recruited from the ranks of reformed addicts. Setting educational standards might disqualify some of these people, many of whom insist their "street smarts" are far more valuable than an academic degree.

"I got more hands-on experience on the streets than anybody could learn in a master's program," said Jody Rosen, a recovered addict who now directs Spectrum of Broward, a drug-free program in Wilton Manors.

Some of the confusion is inevitable considering that the programs were developed from scratch in the early 1970s.

Government records show that early attempts at drug abuse treatment were largely shots in the dark.

"Even though the level of our current knowledge as to effective drug abuse programs is low, we are, I believe, in a position of having to do something more," Elliot Richardson, secretary of Health, Education and Welfare, wrote in a March 17, 1971, memo to President Nixon.

Yet Richardson warned that simply providing vast sums to treatment programs — as much as $160 million in 1973, the first year — wouldn't cure the problem. "Even in the absence of

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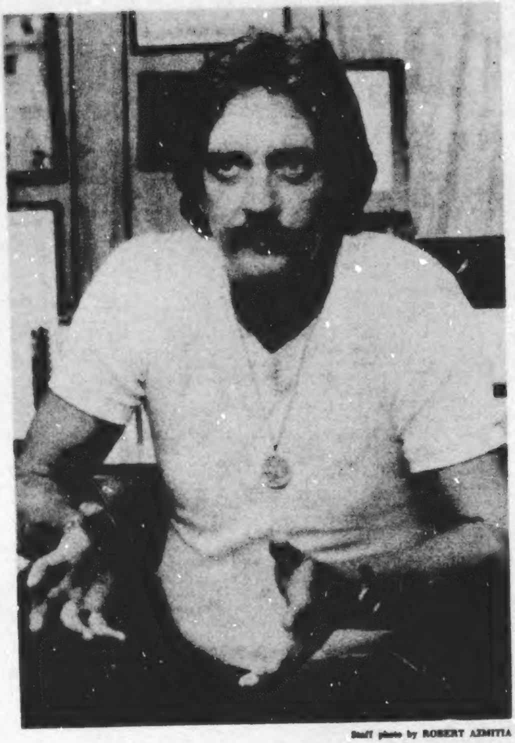
— Elliot Richardson,
Health, Education and
Welfare secretary, in
a 1971 memo to
President Nixon



Staff photo by ROBERT AZMITIA

“I got more hands-on experience on the streets than anybody could learn in a master's program.”
— Former addict Jody Rosen,
director of drug treatment program

hard cost-effectiveness data at this level of additional resources, the law of diminishing returns will set in,” he wrote.

Vast sums were provided, however, and drug abuse treatment became the province of a White House bureaucracy called the Special Action Office for Drug Abuse Prevention.

SAODAP opened in June 1971 with 174 employees and a budget of $3 million. The agency also called upon 36 consultants who were paid between $100 and $138 daily for their services; two of these consultants were dubbed “charity cases” by SAODAP Assistant Director Paul Perito, who claimed they had “scandalously ripped off” the agency.

SAODAP collected high-priced talent. Nixon appointed psychiatrist Jerome Jaffe as administrator; Assistant Director Perito was a lawyer, and at least three other medical doctors came on board.

The agency's strong presidential support was reflected in its budget. SAODAP received $6 million to get started in 1972; the next year, when federal money started flowing to clinics across the country, SAODAP got $200 million.

“SAODAP's organizational structure was fluid and staff responsibilities were constantly changing and poorly defined,” wrote an archivist preserving the records at the National Archives in Washington.

As the organization grew, responsibility “blurred” even further, the archivist wrote, noting that a routine matter often circulated to as many as 30 people before a decision was made.

SAODAP's functions were absorbed by the National Institute on Drug Abuse in 1975; that year NIDA had 400 employees and an annual budget of nearly $250 million.

NIDA now has 287 full-time positions, and a proposed 1984 budget of $71.7 million. The 1984 budget does not represent a decrease because the institute no longer is directly dispensing money to clinics; in fact some areas, notably research, have received substantial increases in budgets.

Jaffe, SAODAP's first director, said the organization made a “remarkable” contribution by organizing disparate elements of the federal bureaucracy into a coordinated attack on drug abuse.

“I think that the way things turned out that we are exceedingly fortunate that we did what we did,” Jaffe said. “It was more luck than anything else.”

Studies may uncover key to addiction

Addiction treatment programs are unlikely to improve dramatically until the causes for the disease become known, scientists say.

"We are in our infancy in understanding the drug addiction process," said Dr. James Cooper, director of medical and professional affairs for the National Institute on Drug Abuse.

Addiction affects all races and economic classes; nobody knows if some people are predisposed to becoming drug-dependent because of a personality disorder, or other factors.

"No one is quite sure how these biological factors come about, whether people are born with them or learn them," said Dr. Donald Jasinski, scientific director of NIDA's Addiction Research Center in Baltimore.

Until this question is answered there will continue to be disagreement about the proper means of treating addicts.

Dr. Vincent Dole thought he had found the answer when he pioneered methadone maintenance in the mid-1960s. Dole, senior physician at Rockefeller University in New York City, theorized that prolonged use of narcotics upset the body's metabolism, rendering the addict incapable of living without drugs. He reasoned that giving an addict methadone is analogous to dispensing insulin to a diabetic.

Today many researchers reject Dole's hypothesis, even if they are unable to disprove it.

Opponents argue that thousands of former heroin addicts have returned to drug-free lives, suggesting that social and environmental factors associated with addiction can be overcome. For example, some American servicemen in Vietnam became heroin-dependent to escape the horrors of the war. Many of these soldiers, however, stopped using the drug once they returned home.

"The assumption [that heroin addiction is a lifelong affliction] doesn't generalize for all patients," said Dr. Edward Tocus, chief of the Food and Drug Administration's drug abuse staff.

Other experts are hopeful that recent advances in brain chemistry may unlock the secrets of narcotics addiction.

In the early 1970s, scientists discovered that the brain emits endorphins, natural opiates which regulate pleasure and pain. The discovery has led some scientists to speculate that endorphin imbalance may predispose some people to becoming drug addicts. If that's true, doctors some day might be able to prevent addiction by correcting the imbalance.

"There is no evidence for or against it," said Dr. Avram Goldstein, director of the Addiction Research Foundation in Palo Alto, Calif. "It is just a plausible hypothesis, but nobody has found a way to test it."

Yet Goldstein said that one day endorphin research might allow scientists to settle the debate about which treatment to use for addicts.

"If [Dole's] metabolic theory is correct then we need to develop a better methadone, but this is still so speculative," he said. "It will be 15 years before there will be a breakthrough. In the meantime, we do the best we can."

Jasinski, of the NIDA research center, believes his agency has found a "better" methadone. The drug is called buprenorphine, a non-addicting painkiller developed by British chemists.

Because the drug gives the addict euphoria but does not produce physical dependence, he suggests that it might be substituted for methadone. However, the drug has yet to be tested fully, and officials have yet to decide whether to continue research on it.

Other scientists are worried that programs which dispense drugs to addicts may be encouraging patients to experiment with a variety of drugs. Particularly worrisome is the fact that many methadone patients tend to abuse alcohol and other drugs while on the program.

"Methadone may inculcate poly-drug dependence, and that might be a dangerous way to go," said Dr. James Ruttenber of the federal Centers for Disease Control in Atlanta.

But because of the limited knowledge it is "very difficult to decide whether methadone is good or bad," Ruttenber said.

Insurance, patients paying larger share

Most tax-funded drug abuse treatment programs are reeling from federal and state budget reductions; at the same time, expensive in-hospital facilities are flourishing in some areas.

"I think that we are moving toward two levels of health care — one for people with money, one for people without it," said Thomas Kirkpatrick, president of the National Association of Drug and Alcohol Abuse Program Directors.

The group claims that federal funding of drug and alcohol treatment programs has been slashed one-third since 1980, from $332 million in fiscal 1980 to $222.8 in fiscal 1985.

"The great bulk of our clients don't have jobs, or insurance, so we can't charge them large fees," Kirkpatrick said.

But drug abusers who have jobs and insurance through their employer increasingly are finding that services are available. No agency has kept statistics, but in recent years the number of hospitals opening units to treat "substance abuse" is believed to have increased.

Marjorie Moe, a spokeswoman for Blue Cross of Florida in Jacksonville, said there has been a "gradual increase" in detoxification services in hospitals.

Detoxification, a 21-day regimen of gradually decreasing doses of methadone, has been criticized because many patients fail to complete the procedure.

Methadone services also are growing in Florida for patients able to pay their way, usually about $5 a day for the drug.

For years, the only methadone maintenance treatment available in Broward and Palm Beach counties has been through for-profit clinics. In Miami, two for-profit programs have opened in recent years; in Orlando, a private company called Central Florida Substance Abuse Treatment Center has received an interim license to run a methadone program, but officials of the state Department of Health and Rehabilitative Services said the center has not opened.

"I assume that if the public sector gets out of the business, then private enterprise will step in," said Dr. James Cooper, director of medical and professional affairs for the National Institute on Drug Abuse.

"The federal government didn't make a permanent [financial] commitment" to drug abuse treatment, said Dr. Jerome Jaffe, who as director of the Special Action Office for Drug Abuse Prevention established the national network of federally funded methadone programs in the early 1970s.

"The support of health care is supposed to be a state responsibility," Jaffe said. "The federal government was only priming the pump."

Some addicts chafe at stiff restrictions

Irvin Williams doesn't expect every addict to thrive in his "therapeutic community."

"It requires the patient to make a commitment for change and live by a structured routine," said Williams, who directs the Lakeview Center's live-in drug abuse treatment program in Pensacola. "Sometimes the clients' motives to change are not as strong as they thought."

Therapeutic communities — programs stressing abstinence from all drugs — are the principal alternative to methadone maintenance treatment for narcotics addicts. Most offer extensive counseling and encourage clients to pursue job training or educational goals.

But these programs remain unacceptable to many drug abusers largely because of the restrictions on personal freedom. In addition, many addicts object to what they view as efforts by staffers at residential programs to intimidate clients, or humiliate them.

"I knew of one place where they made you wear a light bulb around your neck if you forgot to turn off the light," said Bob, who now is receiving methadone treatment at a South Florida clinic.

Though Williams concedes that such attitudes are prevalent, he notes they are based largely on myth. The residential setting can be of immense benefit for some clients, usually those who are younger and do not have extensive histories of drug abuse, he said.

Others who lack responsibility to live on their own, or to resist the temptation to use drugs, also may improve in the supervised setting.

From 30 percent to 40 percent of patients who enroll in the Pensacola program emerge free of drug use; the rest drop out. Of the group discharged drug-free, Williams estimates that 10 percent relapse.

"Those of us in the field for many years recognize the limitation of drug treatment programs," Williams said. "No treatment programs will change a person that is not ready to change."

Therapeutic communities rose to prominence during the 1960s as part of a trend toward community treatment for people with mental health problems; most tried to offer an alternative to the prison-like conditions addicts found at two government-run addiction treatment hospitals such as the one operated for years by the U.S. Public Health Service in Lexington, Ky.

But residential facilities cost as much as $5,000 per patient per year, a factor which limited their acceptance within government. By contrast, outpatient programs would cost about $1,500, whether they dispensed methadone or simply counseled patients regularly.

Some of the facilities also were affiliated with religious orders which discouraged government involvement. In 1981, federal officials reported they could not demonstrate that "religious practices" were related to "favorable outcome" of treatment.

> **"No treatment programs will change a person that is not ready to change."**
> **— Irvin Williams,**
> **Lakeview Center**
> **treatment director**

Methadone remains the treatment offered most addicts; nationwide, about twice as many patients are enrolled in federally funded methadone clinics as in residential drug-free programs.

Nixon administration aides who set up the national drug abuse treatment financing system favored methadone maintenance, not therapeutic communities, for most heroin addicts, who they believed would not remain drug-free.

"Dropout rates [in therapeutic communities] have been very high, only a small minority remain to complete the treatment," reads a draft policy statement developed by the White House Special Action Office for Drug Abuse Prevention, which began funding programs in 1973.

"Many TC's have discouraged and even actively prohibited any evaluation of their results; thus there is only a limited body of knowledge available," the statement reads.

Yet the programs survived largely because many had gained political power through what Nixon aides called "extensive publicity and considerable enthusiasm of its advocates."

The SAODAP statement reflects this power, concluding that the programs should be "available as an option to drug abusers."

"The government never evaluated the therapeutic community. At the time [during the Nixon administration] these programs were out of the question because of the expense," said Dr. Saul Sells, the government's leading evaluator of drug abuse treatment programs.

"If some of these issues came up today it would be a different story," Sells said. "There would be a better balance of treatment approaches."

Today, federal officials acknowledge that the therapeutic community can be effective, even though the programs still are plagued by high dropout rates. Officials have reported that therapeutic communities are slightly more likely than methadone maintenance to lead to abstinence.

Ex-users' fellowship seen as one way out

We have by no means found a "cure" for addiction. We offer only a proven plan for daily recovery.

— Introduction to
Narcotics Anonymous textbook

Don survived a life of drug abuse in New York, several live-in treatment programs that failed to cure his problem, and six years of "misery" in a South Florida methadone program.

"Methadone worked for me to a point. It helped me keep a job," Don said. But four months ago he kicked the methadone habit — vowing never to use drugs again.

"It was very difficult to get off," Don said. "It took two months before I got a good night's sleep. I have no desire to return to the misery [of drug addiction] again."

Don expects to stay "clean" by attending nightly meetings of a Narcotics Anonymous group in Broward County. More than 600 recovering South Florida addicts rely on the fellowship, which stresses abstinence from drugs, including alcohol, and demands service to other members.

"One addict helping another is unparalleled," Don said after a recent session in Davie. "This is a better alternative."

Most NA members are optimistic. Their enthusiasm can be felt in the thunderous applause that greets new arrivals at meetings; it can be seen in the smiles when members come forward to pick up "chips" symbolizing continued sobriety; it can be heard in the self-mocking laughter that erupts as a speaker tells his story of junkie self-deception and degradation.

But even the most ardent NA proponents concede that many faces become familiar, only to disappear. Despite a safety net of "sponsors" and a network of telephone contacts on call to help members resist the temptation to take drugs, as many as two-thirds of the fellowship's participants relapse. The failure rate is believed to be consistent nationwide.

"We don't keep any statistics, but I would say that we lose too many," said one local member. "Most people go back to drugs. We continue to carry a message, so that the minority that succeed will grow and grow."

Though NA enthusiasts agree that not everyone attains the goals, they insist the program's concepts are sound.

"This is a perfect program for imperfect people," said Paul, who credits nightly NA meetings with helping him steer clear of heroin during the past three years. "The program can't fail, but everybody may not be willing to make it work."

Narcotics Anonymous was formed in southern California in 1953. The organization claims "many thousand" members across the country and operates a "World Service" office in Los Angeles.

Federal officials at times have expressed interest in funding the self-help programs, but NA groups have sought to maintain their independence. Similarly, the organizations decline to endorse any drug abuse treatment program, though many chapters regularly use the facilities of proprietary institutions for meetings.

Several loosely affiliated NA groups have existed in South Florida since about 1975. All are supported by member contributions. The only criterion for membership is a sincere desire to stop using drugs.

"We are not a treatment program. We are a set of principles to live by," one member said. "This is the best psychotherapy known to man."

Fred Schulte

Methadone research: A paper chase

Early in reporter Fred Schulte's examination of methadone treatment, it became clear that the federal bureaucracy has been collecting paperwork about the programs for a decade.

Just that. Collecting.

Thousands of pages of reports from methadone clinics across the country have been mailed to Washington, where the numbers from the reports were dutifully punched into computers operated by the Food and Drug Administration, National Institute on Drug Abuse and Drug Enforcement Administration.

That's where the information stayed until Schulte used the Freedom of Information Act to force the agencies to release it. More than two dozen separate written requests were required to obtain the data — much of which never had been published or reviewed.

DEA prepared the first complete listing of methadone deaths and injuries ever extracted from its massive data banks. The FDA also prepared a computer tally of methadone deaths and "adverse reactions." Schulte sorted through hundreds of pages of annual treatment reports submitted to FDA by clinics to compile statistics on patient deaths and injuries.

NIDA and FDA also produced thousands of pages from technical manuals and federally funded research studies. In many cases, special requests were required to separate the statistics on methadone. More than 100 medical-journal articles on methadone treatment also were reviewed.

Schulte also examined most of 113 cubic feet of documents from the Special Action Office for Drug Abuse Prevention (SAODAP), created by President Nixon late in 1971. The White House-based office, whose functions were merged into NIDA in 1975, established the methadone program.

Officials of the National Archives in Washington, where the documents are stored, said few, if any, researchers ever had reviewed the SAODAP files before. The review necessarily was incomplete; some records of Nixon and his top aides are sealed pending the outcome of lawsuits.

The FDA also provided 7,000 pages of documents pertaining to Florida methadone programs — including findings of 81 FDA inspections of clinics in the state during the past 10 years.

Methadone-related deaths in Broward and Dade counties were found through a search of files of all drug-related deaths during 1980 and 1981. Deaths during 1982 were not examined because no national comparison is possible; the FDA has not yet asked clinics to submit those reports.

Medical examiners' reports identified some victims as being enrolled in methadone maintenance programs and confirmed presence of methadone through laboratory tests. Circumstances of death were reconstructed through morgue documents and reports prepared by police in seven South Florida jurisdictions.

Methadone thefts in Florida were isolated by examining all drug thefts reported to the DEA in Miami during the past five years.

Some measures only could be estimated because of limitations in the government data; others had to be calculated from various reports. Government officials did not dispute the validity of any of the computations.

Interviews were conducted with dozens of government officials and experts in drug abuse treatment, methadone program physicians and other staff members, clinic patients and police officials in Florida and across the country.

Schulte joined the *News* and *Sun-Sentinel* in 1978, serving as medical writer and investigative reporter. He has received awards for investigative reporting and specialty writing from the Florida Press Club and other organizations.

DRUG ABUSE UPDATE

NUMBER 5
FROM THE
FAMILIES IN ACTION DRUG INFORMATION CENTER
JUNE 1983

DRUG USE AND EFFECTS

ALCOHOL

ALCOHOL-RELATED ACCIDENTS ARE UP

A new study by the National Highway Traffic Safety Administration shows alcohol is now involved in some 56 percent of all fatal traffic accidents. Last year there were two million alcohol-related accidents in which 700,000 people were injured and 24,000 to 27,000 killed. The report is entitled "Alcohol Involvement in Traffic Accidents." (WP 4/21/83, TJ 5/1/83)

BEER CONSUMPTION FAILS TO RISE

For the first time in 20 years, beer consumption in the United States has leveled off. Americans drank 5.56 billion gallons of beer in 1982.

Industry analyst Robert Natale says that figure is unlikely to rise because of higher legal drinking ages in some states, harsher drunk-driving penalties, reduced population growth and the older average age of Americans. (USAT 4/22/83)

CAFFEINE

CAFFEINE CONTROVERSY CONTINUES, LINKING THE DRUG TO A VARIETY OF DISORDERS

Caffeine, a central nervous system stimulant, affects the cerebral cortex, the thinking part of the brain, and the medula, the section of the brain which regulates muscles including the heart.

But is caffeine harmful to humans? Conflicting reports make it difficult to answer this question.

The Harvard Medical School Health Letter says, "There are no good studies to support the claim of danger in humans." However, the Food and Drug Administration may drop caffeine from its list of chemicals generally thought to be safe because of long-term use without noticeable ill-effect.

Caffeine increases heart rate and blood pressure as well as the production of adrenaline, urine, and stomach acid. It also elevates the speed at which the body burns calories.

Many people function better with caffeine in their systems, but too much caffeine can cause nervousness, heart palpitations, heart-rhythm changes, dizziness and shaking. Some research links caffeine to birth defects, complications of pregnancy, cancer, heart attacks, blood pressure problems, cystic breast disease and behavioral problems.

"Ulcer victims and people with high blood pressure or other major risk factors for heart disease might consider reducing or eliminating caffeine .... For others, caffeine is probably near the bottom of the list of dietary and other health concerns," say the editors of Changing Times. (AC 4/12/83)

COCAINE

SILICON VALLEY EXECUTIVES CONSUME A TON OF COCAINE PER YEAR

High-technology executives who live in the Silicon Valley near San Jose, California, are turning on with cocaine, reported to be as easy to get in the valley as marijuana. Lt. Tom Shigemasa, commander of the San Jose Police Narcotics Division, says cocaine use in the valley is a "monumental problem." (AC/UPI 3/22/83)

TWENTY MILLION AMERICAN COCAINE USERS MAKE COCAINE TRADE A $25 BILLION BUSINESS

A national cocaine survey conducted for Time Magazine by Yankelovich, Skelly and White shows the number of Americans who use cocaine increased from 15 million to 20 million. That figure amounts to some 11 percent of the U.S. adult population. The surveyors say blue-collar workers are more likely than professionals to have tried the drug.

Cocaine destroys nasal membranes, constricts blood vessels and depresses the appetite. Duke University pharmacologist Gerald Rosen says liver cells are destroyed by cocaine. Researchers at Massachusetts General Hospital say cocaine free basers often suffer serious lung damage as well as nearly certain drug dependence. (TM 4/11/83)

DIET PILLS

DRUG FOUND IN DIET PILLS AND SOLD AS AMPHETAMINE IS HARMFUL

Phenylpropanolamine (PPA), a drug found in diet pills and some nasal decongestants, can cause strokes, high blood pressure and psychiatric problems says Dr. Shirley Mueller, assistant professor of neurology at the University of Indiana Medical Center and director of neurology at Wishard Memorial Hospital in Indianapolis. She has turned over her findings to the U.S. Food and Drug Administration for investigation.

In a letter to the New England Journal of Medicine, Dr. Mueller says PPA is implicated in "psychic disturbances, headaches, seizures, stroke and death in previously healthy people." (AJ/AP 2/14/83, AJ/UPI 3/17/83)

HEROIN

CHINA WHITE, A DEADLY SYNTHETIC HEROIN, RESURFACES IN MINNESOTA

Police in Minneapolis, Minnesota, warn there is no cure for overdosing on a synthetic heroin called China White which has reappeared in that community after a two-year absence. Two deaths in Minnesota have recently been attributed to China White, which can be up to 50 times more potent than heroin. The drug killed at least 12 people between 1979 and 1981 in California and Arizona.

Sold as heroin, China White is actually a methyl analog of an analgesic called fentanyl, a component of a morphine-like injection made by Janssen Pharmaceutical Inc. It is marketed as Sublimase.

DRUG ABUSE UPDATE

Published by Families in Action, Inc., Suite 300, 3845 North Druid Hills Road, Decatur, GA 30033, 404-325-5799

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AC—Atlanta Constitution
AJ—Atlanta Journal
AJC—Atlanta Journal Constitution
AJC/AW—Atlanta Journal Constitution Atlanta Weekly
AP—Associated Press
BG—Boston Globe
DNS—DeKalb News Sun
JAMA—Journal of the American Medical Association
NYT—New York Times
PDR—Physician's Desk Reference
TM—Time Magazine
TJ—The Journal (Addiction Research Foundation)
UPI—United Press International
USAT—U.S.A. Today
WP—Washington Post
WRS—Weekly Reader Survey

NEW DRUG ABUSE SURVEYS: GOOD NEWS, BAD NEWS

There is both good news and bad news in two surveys just released by the National Institute on Drug Abuse. One is the High School Senior Survey, conducted annually since 1975 by the University of Michigan Institute for Social Research. The other is the National Household Survey on Drug Abuse, conducted every two to three years by the George Washington University Social Research Group. The National Institute on Drug Abuse funds both surveys.

The good news is that marijuana use among youngsters and seniors is going down. The bad news is that adolescent drug use in the United States is still higher than in any other country in the world. As the charts on page 12 indicate, we still have a long way to go.

There is some other good news and that is shown by the red lines on the charts on page 11. By 1978 the parents' movement to prevent drug abuse among children was in full swing. Parents defined drug abuse as any use of illegal drugs by children and said a resounding "no" to "responsible use," head shops, and decriminalization. By insisting that marijuana be seen as a health problem rather than a legal problem exclusively and by insisting that teaching abstinence can work (after all, we don't teach people to smoke cigarettes responsibly, we teach them to quit because cigarettes aren't good for their health), parents began to establish clear signals about what was — and was not — acceptable behavior for children. And society has begun to hear the parents' message.

Since 1978 no state has decriminalized marijuana. Since 1978 most states have outlawed head shops. Since 1978 five monthly magazines that catered exclusively to the drug culture have stopped publishing. Flash, HiLife, Head, Stone Age, and Dealer are all out of business; only High Times is left. Since 1978 a growing number of children's role models — sports heroes, movie stars, rock singers — have lent their voices to no-drugs, rather than pro-drugs messages. And since 1978 hundreds of thousands of parents, educators, service organizations, government agencies, even the First Lady of the United States, are educating people about the health hazards of drug abuse among youngsters.

In addition to the decline in marijuana use, attitudes have changed even more dramatically. Since 1978 the number of seniors who feel regular marijuana use entails great risk has risen from 35 to 60 percent, while the number who fear their friends would disapprove of such behavior has risen from 34 to 75 percent.

The household survey tells us one more encouraging thing about regular marijuana use among all age groups (12 to 17, 18 to 25, 26 and over): it's down by 2½ million people. There were 22.6 million regular users in 1979 compared to 20.1 million regular users now.

Before we hang up our parent group hats, however, there is still a lot of bad news. In the words of the survey, it would be a disservice to leave the impression that drug abuse among youth is anywhere close to being solved.

- Two-thirds of all youngsters try an illicit drug before they finish high school.
- More than one-third have used illicit drugs other than marijuana.
- One of every 16 seniors still smokes pot every day.
- Thirty percent smoked cigarettes in the month preceding the survey. Many now are or will become daily smokers.
- Ninty-three percent will try alcohol before they graduate. Seventy percent used it in the month before the survey.

Clearly, we still have a long way to go. But we'd like to pause for a moment to give everyone a pat on the back. What we are doing is working. We haven't stopped adolescent drug abuse completely, but we *have* figured out how to do it. The surveys show prevention works. They offer the most solid evidence to date that all the work it takes to form a parents' group is worth it.

So hang in there, stick with it, keep at it. Our common goal is not only attainable; it may not be so far away as we once feared.

PLAN NOW TO ATTEND NATIONAL FEDERATION OF PARENTS' 2nd ANNUAL FALL CONFERENCE

The National Federation of Parents for Drug-Free Youth will hold its Second Annual Conference at the Twin Bridges Marriott Hotel in Washington, D.C., September 26, 27 and 28, 1983.

Last year's conference was attended by 500 parent group leaders from 46 states and 4 foreign countries. Experts in the parent group movement and in the fields of law enforcement, treatment, and prevention shared their expertise with conferees. Nearly every federal government official who has any responsiblity for drug abuse addressed the conference, including the Surgeon General of the United States.

The conference was highlighted by a luncheon honoring First Lady Nancy Reagan who praised the parents' drug prevention movement and who in turn received their gratitutde in a series of testimonials from parent group leaders across the nation.

Because of space limitations, registration will have to be on a first-come, first-served basis: Call 301-649-7100.

The Physician's Desk Reference says of fentanyl: "As with other narcotic analgesics, the most common serious adverse reactions ... are respiratory depression, apnea (temporary stopping of breathing), muscular rigidity and braycardia. If these remain untreated respiratory arrest, circulatory depression or cardiac arrest could occur...As with other CNS (central nervous sytem) depressants, patients who have received Sublimase (fentanyl) should have appropriate surveillance. Resuscitation equipment and a naracotic antagonist should be readily available to manage apnea." (USAT 4/27/83, NYT 12/30/80, PDR 1983)

L.S.D.

SEVEN-YEAR-OLD HOSPITALIZED, DAD JAILED, AFTER CHILD LICKED L.S.D. STAMP

A Stockbridge, Georgia, second-grader was hospitalized when she became ill at school from the effects of an accidental overdose of L.S.D. Seven-year-old Michelle Mullinax took what she thought was a decorative stamp from her father and licked it to place the decoration on her notebook. The stamp was coated with L.S.D., and school officials became concerned when she began to hallucinate. They contacted her parents who took her to the hospital.

Based on a statement from the child, police arrested Michelle's father, Jack Mullinax, 33, for violation of the Georgia Controlled Subatances Act. (AC 5/12/83)

PAINKILLERS

HEART, KIDNEY DISORDERS LINKED TO PAINKILLERS

High doses of painkillers containing phenacetin taken over a long period of time increase the risk of urinary tract and kidney disorders as well as cardiovascular disease, according to an 11-year old study conducted in Switzerland and reported in the New England Journal of Medicine. Phenacetin can be found in both over-the-counter and prescription painkillers such as APC Tablets, Emphrazil, P.A.C. Compound and Sinubid. These are used to relieve fever, muscle spasms, and inflammations.

Researchers say "Heavy users of phenacetin had a four-times greater risk of death due to urinary tract or kidney disease than moderate or non-users of the drugs, although the risk was still low." AJ/UPI 2/17/83)

MANUFACTURER OF TALWIN CHANGES FORMULA TO REDUCE ABUSE

Popular among drug users is "T's and Blues," a combination of Talwin, a prescription painkiller and Pyribenzamine, an over-the-counter blue antihistamine tablet. In an effort to reduce abuse of its product, Talwin's manufacturer, Winthrop Laboratories, has reformulated the drug. Unpleasant withdrawal symptoms will now occur if Talwin is crushed and injected. (NYT 3/9/83, JAMA 9/12/80)

LONG TERM USE OF ANALGESICS MAY DAMAGE KIDNEYS

Dr. William M. Bennett of the Oregon Health Sciences University says that some people who use aspirin or drugs containing acetaminophen (found in Tylenol and Anacin 3) daily for a long period of time may be seriously damaging their kidneys.

Dr. Bennett, who is professor of pharmacology and head of kidney treatment at the Portland medical school, told a symposium at the National Kidney Foundation that using 6 to 8 tablets a day might cause problems. He said from 5 to 10 percent of patients who need kidney transplants or dialysis treatments are chronic users of painkillers.

Bennett says he does not want to discourage anyone from using painkillers under a doctor's supervision, "but I believe they should have an annual checkup of blood pressure and urine, and a blood test for signs of kidney damage, including any buildup of creatinine, a protein that accumulates when the kidneys don't work."

He cautions people against regular use of over-the-counter painkillers for "minor aches and pains." Dr. Bennett says damage to the kidneys sometimes produces no symptoms until the damage is quite severe. (WP 3/2/83)

TOBACCO

CIGARETTE SMOKING NATION'S NUMBER ONE DRUG PROBLEM

"Why People Smoke Cigarettes," a pamphlet released by the U.S. Office on Smoking and Health, calls cigarette smoking "the most widespread example of drug dependence" in America. Smoking causes more illness and death than all other drugs, says the pamphlet.

A spokeswoman for the Smoking and Health office says, "It's (the pamphlet) a stronger characterization of cigarette smoking as a dependence than we have said in the past. We came to the conclusion that maybe it was time we did." (AC/AP 3/7/83)

PASSIVE SMOKING CAN CAUSE CANCER

A study of cancer records at Lancaster General Hospital in Pennsylvania shows that non-smokers who breathe air tainted with cigarette smoke have a higher rate of lung cancer than non-smokers who do not have much contact with smokers.

The study is reported in the February issue of the Journal of the Indiana State Medical Association. Dr. Gus H. Miller, a psychologist and mathematician who heads the Studies on Smoking Clinic at Edinboro, Pennsylvania, conducted the study.

Dr. Miller chose Lancaster County because it has the largest population of Amish, a religious sect whose members neither smoke nor mingle with outsiders. Hospital records show that of 348 lung cancer deaths only one was Amish, and that person was related to a cigar smoker. "The smokeless environment (in which the Amish live) appears to be the most likely reason for the extremely low incidence of lung cancer in the Amish population," Dr. Miller concludes. (AJC/AP 3/13/83)

CHEWING TOBACCO AND SNUFF LEAD TO DENTAL PROBLEMS

Two dentists from Emory University, Drs. Steven Offenbacher and Dwight R. Weathers, report that one-fourth of young boys, aged 10 to 16, that they studied, are using snuff and chewing tobacco regularly. The dentists conducted the study to assess the relationship between tobacco use and gum and tooth disorders. They concluded that only 19 percent of the non-users exhibited receeding gums, which leads to tooth decay. But 47 percent of the tobacco chewers and 55 percent of the snuff users had the problem. Interestingly, only 5 percent of 566 males studied smoked cigarettes.

The doctors say the popularity of chewing tobacco and snuff among young boys seems to be "related to a macho image." (AC 4/21/83)

SURVEYS

WEEKLY READER POLL SHOWS PRESSURE TO USE DRUGS STARTS IN FOURTH GRADE

Children report they feel pressure to use alcohol and other drugs as early as fourth grade. A Weekly Reader survey of 500,000 children in grades 4 through 12 finds that lower-grade youngsters use drugs "to feel older," middle-grade children "to fit in," and high school students "to have a good time."

Fourth and fifth graders surveyed say they learn about drug dangers mainly from TV, movies and parents, while sixth graders learn from school as well. About 75 percent of fourth graders feel there is "some danger or great risk" in having one drink or smoking one joint of marijuana on a daily basis. (WRS)

LEVEL OF DRUG ABUSE HIGH IN D.C.

Washington, D.C., Mayor Marion Barry launched an intense anti-drug campaign with the release of statistics that show drug addiction in his city is at an all-time high. The District's alcoholism rate is the second highest in the nation.

Some 15,000 of Washington's 630,000 residents are drug addicts; another 50,000 to 60,000 are alcoholics. One-third of the defendants who come before the D.C. Superior Court are there on drug-related charges. Police Chief Maurice Turner says more than half of all police calls are drug-related complaints. (WP 4/22/83)

HIGH SCHOOL SENIOR DRUG USE: 1975-1982

EVER USED

	'75	'76	'77	'78	'79	'80	'81	'82
Marijuana	47%	53%	56%	59%	60%	60%	60%	59%
Inhalants	NA	10	11	12	13	12	12	13
Amyl & Butyl Nitrites	NA	NA	NA	NA	11	11	10	10
Hallucinogens	16	15	14	14	14	13	13	13
LSD	11	11	10	10	10	9	10	10
PCP	NA	NA	NA	NA	13	10	8	6
Cocaine	9	10	11	13	15	16	17	16
Heroin	2	2	2	2	1	1	1	1
Other Opiates	9	10	10	10	10	10	10	10
Stimulants	22	23	23	23	24	26	32	36
Sedatives	18	18	17	16	15	15	16	15
Barbiturates	17	16	16	14	12	11	11	10
Methaqualone	8	8	9	8	8	10	11	11
Tranquilizers	17	17	18	17	16	15	15	14
Alcohol	90	92	93	93	93	93	93	93
Cigarettes	74	75	76	75	74	71	71	70

DAILY USERS

	'75	'76	'77	'78	'79	'80	'81	'82
Marijuana	6%	8%	9%	10.7%	10.3%	9.1%	7%	6.3%
Inhalants	NA	0.0	0.0	0.1	0.0	0.1	0.1	0.1
Amyl & Butyl Nitrites	NA	NA	NA	NA	0.0	0.1	0.1	0.0
Hallucinogens	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
LSD	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0
PCP	NA	NA	NA	NA	0.1	0.1	0.1	0.1
Cocaine	0.1	0.1	0.1	0.1	0.2	0.2	0.3	0.2
Heroin	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other Opiates	0.1	0.1	0.2	0.1	0.0	0.1	0.1	0.1
Stimulants	0.5	0.4	0.5	0.5	0.6	0.7	1.2	1.1
Sedatives	0.3	0.2	0.2	0.2	0.1	0.2	0.2	0.2
Barbiturates	0.1	0.1	0.2	0.1	0.0	0.1	0.1	0.1
Methaqualone	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1
Tranquilizers	0.1	0.2	0.3	0.1	0.1	0.1	0.1	0.1
Alcohol	5.7	5.6	6.1	5.7	6.9	6.0	6.0	5.7
Cigarettes	26.9	28.8	28.8	27.5	25.4	21.3	20.3	21.1

USED IN PAST MONTH

	'75	'76	'77	'78	'79	'80	'81	'82
Marijuana	27%	32%	35%	37%	37%	34%	32%	29%
Inhalants	NA	1	1	2	2	1	2	2
Amyl & Butyl Nitrites	NA	NA	NA	NA	2	2	1	1
Hallucinogens	5	3	4	4	4	4	4	3
LSD	2	2	2	2	2	2	3	2
PCP	NA	NA	NA	NA	2	1	1	1
Cocaine	2	2	3	4	6	5	6	5
Heroin	*	*	*	*	*	*	*	*
Other Opiates	2	2	3	2	2	2	2	2
Stimulants	8	8	9	9	10	12	16	14
Sedatives	5	5	5	4	4	5	5	3
Barbiturates	5	4	4	3	3	3	3	2
Methaqualone	2	2	2	2	2	3	3	2
Tranquilizers	4	4	5	3	4	3	3	2
Alcohol	68	68	71	72	70	72	71	70
Cigarettes	37	39	38	37	34	31	29	30

NATIONAL HOUSEHOLD SURVEY ON DRUG ABUSE
LIFETIME PREVALENCE OF DRUG USE: 1972-1982

YOUTH: AGE 12-17

	'72	'74	'76	'77	'79	'82
Marijuana	14.0%	23.0%	22.4%	28.0%	30.9%	27.3%
Hallucinogens	4.8	6.0	5.1	4.6	7.1	5.2
Cocaine	1.5	3.6	3.4	4.0	5.4	6.5
Heroin	.6	1.0	.5	1.1	.5	*
Nonmedical use of:						
Stimulants	4.0	5.0	4.4	5.2	3.4	6.5
Sedatives	3.0	5.0	2.8	3.1	3.2	5.8
Tranquilizers	3.0	3.0	3.3	3.8	4.1	4.9
Analgesics	NA	NA	NA	NA	3.2	4.2
Any Nonmedical Use	NA	NA	NA	NA	7.3	10.3
Alcohol	NA	54.0	53.6	52.6	70.3	65.2
Cigarettes	NA	52.0	45.5	47.3	54.1	49.5

YOUNG ADULTS: AGE 18-25

	'72	'74	'76	'77	'79	'82
Marijuana	47.9%	52.7%	52.9%	59.9%	68.2%	64.1%
Hallucinogens	NA	16.6	17.3	19.8	25.1	21.1
Cocaine	9.1	12.7	13.4	19.1	27.5	28.3
Heroin	4.6	4.5	3.9	3.6	3.5	1.2
Nonmedical use of:						
Stimulants	12.0	17.0	16.6	21.2	18.2	18.0
Sedatives	10.0	15.0	11.9	18.4	17.0	18.7
Tranquilizers	7.0	10.0	9.1	13.4	15.8	15.1
Analgesics	NA	NA	NA	NA	11.8	12.1
Any Nonmedical Use	NA	NA	NA	NA	29.5	28.4
Alcohol	NA	81.6	83.6	84.2	95.3	94.6
Cigarettes	NA	68.8	70.1	67.6	82.8	76.9

OLDER ADULTS: AGE 26 +

	'72	'74	'76	'77	'79	'82
Marijuana	7.4%	9.9%	12.9%	15.3%	19.6%	23.0%
Hallucinogens	NA	1.3	1.6	2.6	4.5	6.4
Cocaine	1.6	.6	1.6	2.6	4.3	8.5
Heroin	*	.5	.5	.8	1.0	1.1
Nonmedical use of:						
Stimulants	3.0	3.0	5.6	4.7	5.8	6.2
Sedatives	2.0	2.0	2.8	2.8	3.5	4.8
Tranquilizers	5.0	2.0	2.7	2.6	3.1	3.6
Analgesics	NA	NA	NA	NA	2.7	3.2
Any Nonmedical Use	NA	NA	NA	NA	9.2	8.8
Alcohol	NA	73.2	74.7	77.9	91.5	88.2
Cigarettes	NA	65.4	64.5	67.0	83.0	78.7

NA indicates data not available. * indicates less than .5%

TERMS: Ever Used: Used one or more times. Daily Users: Used 20 or more times in the month before survey. Used in Past Month: Used at least once in the 30 days prior to survey. Used in Last Year: Used in the 12 months prior to survey.

SOURCE: Student Drug Use in America, 1975-1982, National Institute on Drug Abuse

CURRENT DRUG USE: 1972-1982

YOUTH: AGE 12-17

	'72	'74	'76	'77	'79	'82
Marijuana	7.0%	12.0%	12.3%	16.6%	16.7%	11.5%
Hallucinogens	1.4	1.3	.9	1.6	2.2	1.4
Cocaine	.6	1.0	1.0	.8	1.4	1.6
Heroin	*	*	*	*		*
Nonmedical Use of:						
Stimulants	NA	1.0	1.2	1.3	1.2	2.6
Sedatives	NA	1.0	NA	.8	1.1	1.3
Tranquilizers	NA	1.0	1.1	.7	.6	.6
Analgesics	NA	NA	NA	NA	.6	.8
Any Nonmedical Use	NA	NA	NA	NA	2.3	3.7
Alcohol	NA	34.0	32.4	31.2	37.2	26.9
Cigarettes	NA	25.0	23.4	22.3	12.1	14.7

YOUNG ADULTS: AGE 18-25

	'72	'74	'76	'77	'79	'82
Marijuana	27.8%	25.2%	25.0%	27.4%	35.4%	27.5%
Hallucinogens	NA	2.5	1.1	2.0	4.4	1.6
Cocaine	NA	3.1	2.0	3.7	9.3	7.1
Heroin	NA	*	*	*	*	*
Nonmedical Use of:						
Stimulants	NA	3.7	4.7	2.5	3.5	4.7
Sedatives	NA	1.6	2.3	2.8	2.8	2.6
Tranquilizers	NA	1.2	2.6	2.4	2.1	1.6
Analgesics	NA	NA	NA	NA	1.0	1.0
Any Nonmedical Use	NA	NA	NA	NA	6.3	7.1
Alcohol	NA	69.3	69.0	70.0	75.9	67.9
Cigarettes	NA	48.8	49.4	47.3	42.6	39.5

OLDER ADULTS: AGE 26 +

	'72	'74	'76	'77	'79	'82
Marijuana	2.5%	2.0%	3.5%	3.3%	6.0%	6.7%
Hallucinogens	NA	*	*	*	*	*
Cocaine	NA	*	*	*	.9	1.2
Heroin	NA	*	*	*	*	*
Nonmedical Use of:						
Stimulants	NA	*	*	.4	.5	.3
Sedatives	NA	*	.5	*	*	*
Tranquilizers	NA	*	*	*	*	*
Analgesics	NA	NA	NA	NA	*	*
Any Nonmedical Use	NA	NA	NA	NA	1.1	1.2
Alcohol	NA	54.5	56.0	54.9	61.3	57.1
Cigarettes	NA	39.1	38.4	38.7	36.9	34.1

NA indicates data not available. * indicates less than .5%

SOURCE: National Household Survey on Drug Abuse, 1982, National Institute on Drug Abuse

Page 4

DRUGS AND CELEBRITIES

FIRST LADY TO HOST PUBLIC BROADCASTING SERVICE SHOW TO COMBAT DRUGS

In her personal crusade to fight teenage drug and alcohol abuse, First Lady Nancy Reagan will host a two-part public television series, "The Chemical People," next November 2 and 9. At a White House briefing Mrs. Reagan said, "We are in danger of losing an entire generation unless we act now to educate ourselves and our children."

The two programs will be broadcast in conjunction with town meetings local Public Broadcasting Service stations are setting up to further education and prevention. (AC 3/22/83, AJ 4/13/83)

DRUGS CHANGE BEATLES' LIVES

When Bob Dylan offered the Beatles marijuana in 1964, he was incredulous that they had never smoked it. He thought John Lennon's words to a song "I can't hide" were "I get high."

Up until that time the Beatles had scorned the use of marijuana, putting it in the same category as that of heroin. They accepted Dylan's offer of something "organic and green." From that time on their lives as well as their music changed.

According to a new book about the Beatles, entitled *The Love You Make* by Peter Brown and Steven Gaines, George and John experimented with LSD with frightening results. Drugs remained a large part of their lives, and by June, 1972, John Lennon, because of drug and anti-war activities, was under strict government surveillance and threatened with deportation. (AJ 4/11/83)

TENNESSEE WILLIAMS ON DRUGS, BROTHER SAYS

Tennessee Williams never forgave his brother Dakin for having him hospitalized for drug treatment over ten years ago and therefore cut him from his will, claims brother Dakin Williams. Although he produced no proof, Dakin voiced his suspicions that the playwright, who left the bulk of his ten-million-dollar estate to the Institute of Arts and Letters for Indigent Writers in New York, was back on drugs.

Insisting that he does not need the money because he is writing a biography of his brother and hopes to make a million dollars, Dakin plans to sue the estate whose attorneys are treating him like a "poor relation." (AJC/UPI 2/26/83, AJ 3/7/83)

SON OF FORMER NEW YORK MAYOR JOHN LINDSAY CHARGED

John Lindsay, Jr., 22, son of former New York Mayor John Lindsay, was arrested and charged with possessing and selling cocaine. At his arraignment, young Lindsay pleaded innocent. If found guilty, he could spend up to 15 years in prison. (AC 4/1/83)

DRUGS AND CRIME

STUDY SUGGESTS DRUG USE RESPONSIBLE FOR RISE IN VIOLENT TEEN CRIMES

In an effort to learn whether the rising teen crime rate of the 1970's occurred because there were more teenagers living during that decade or because teens themselves were more violent than their predecessors, Wharton School professor Martin Wolfgang studied school and police records of 28,000 young people born in Philadelphia, Pennsylvania, in 1958. He compared these records to those of a similar study he had conducted earlier involving 10,000 people born in 1945.

Professor Wolfgang conducted the study for the United States Department of Justice. He says 1970 youth caused "an escalation of violent criminality..." The study shows "not more kids getting into trouble, but the same small number committing more crimes and more violent crimes." Wolfgang suggests the increase is due to the widespread use of drugs by young people in the 1970's. Heavy drug use is not a characteristic of 1960's teenagers. (AC/UPI 2/25/83)

POLL SHOWS DRUG USE BY INMATES PREVALENT PRIOR TO ARREST

The Washington Post questioned 238 male inmates of Lorton Reformatory, the District of Columbia's city jail, to determine why they got into trouble with the law. Fast money for food, cars and drugs were the answers. Sixty-five percent of the inmates said they were using marijuana before they went to jail, while 43 percent admitted to using other drugs as well. (WP 2/17/83)

HEROIN ADDICTS MORE LIKELY NOW THAN IN THE PAST TO COMMIT VIOLENT CRIMES FOR MONEY

Several recent studies funded by the National Institute on Drug Abuse point to a disturbing trend among heroin addicts. In the past they committed mainly property crimes, but now their crimes are more violent. Prison inmates who are heroin addicts say if there is a chance to get money from their victims, they will resort to violence. The studies show that only a small percentage of crimes committed by addicts result in arrests.

One of the more positive conclusions of the new research is that when heroin addicts stop using drugs they commit significantly fewer crimes. One study, for example, charted a 70 percent reduction in crime when addicts became drug free. (AJC/AW 2/13/83)

CRIME INCREASES IN AREA OF VIDEO ARCADE

When a video arcade moved into a southeast District of Columbia shopping center, surrounding merchants and residents reported an increase in crime. Purse-snatchings, drug-trafficking and vandalism escalated as crowds of teenagers frequented the area. The arcade was then closed because the owners, two District police officers, were operating without a license. (WP 3/16/83)

DRUGS AND CULTIVATION, PRODUCTION

GEORGIA POT FARMERS GROW POTENT STRAIN OF MARIJUANA

Some of Georgia's illegal marijuana growers are using sophisticated cultivation techniques to produce plants which are very potent. Lt. Michael Chumley, aviation commander of the Georgia State Patrol, says the plants, called sinsemilla, are in many cases equal to or stronger than marijuana smuggled into the country from Colombia. Chumley says one sinsemilla plant can often yield three pounds of marijuana worth about $2,500 per pound.

Last year, Chumley's unit confiscated some $200 million worth of marijuana in the state. Because of the success of the program, his aviation unit received the highly coveted and prestigious Hughes Law Enforcement Award for 1982. (AJ 3/9/83)

GOVERNMENT DESTROYED MORE POT THAN PREVIOUSLY THOUGHT TO EXIST IN U.S.

Efforts to eradicate domestically cultivated marijuana resulted in the destruction of considerably more pot than the U.S. Drug Enforcement Administration estimated was growing in the United States. The Administration has now revised its estimates upward.

The amount of marijuana destroyed

fluctuated from one state to another. A Drug Enforcement Administration spokesman says as much as 50 percent of Virginia's illegal crop was burned. Forty percent of the Oregon and California crops were similarly destroyed. (WP 3/12/83)

DRUGS AND DEATH

ALCOHOL

TWO TEENS PLEAD GUILTY IN DROWNING OF BOY DURING DRINKING PARTY

Two teenage boys, 15 and 17, accused of contributing to the death of a 16-year-old who drowned in Lake Hopatcong, New Jersey, have pleaded guilty and face prison terms of five to ten years and fines of $100,000. (This is a followup to a story in the December 1982 issue of Drug Abuse Update: Teen Beer Party Ends in Tragedy.)

The drowning was preceded by a fight among several youths who were attending a drinking party. The drowning victim Paul Stevens wound up in the lake. When he attempted to get out of the water, the other youths refused to let him do so. (NYT 3/9/83)

TWO "TYPICAL" PARTIES END IN TRAGIC SLAYING OF GEORGIA TEEN

Drinking was going on at two teen parties in affluent Cobb County, north of Atlanta, Georgia, on Friday evening, April 15. One was a birthday party for 17-year-old Diane Packard of Wheeler High School. Diane's parents were out of the way in an upstairs bedroom during the evening. Ten minutes away from Diane's home, a football player from rival Walton High School was having a party for his teammates. His parents were out of town for the weekend.

The Walton party received a call saying that a girl from their school had been "stood up" that night by a Wheeler High boy, so the football players, some armed with knives, loaded up into cars to "crash" the Wheeler High party in search of the young man. A fight between the boys from both high schools resulted in the stabbing death of Todd Alan Peters, age 17 of Wheeler High School. Bryan Keith Carter, an 18-year-old football player from Walton, has been charged with the slaying. It turned out that the Wheeler boy the Walton students were looking for was not at the party, nor had he "stood up" his date for the evening. He was merely late picking her up because of a lengthy baseball game, which he was playing in another county.

Police reported they received four complaints from neighbors about "loud, boisterous activity and drunken behavior" at the Walton party, but when they responded to the calls the neighbors claimed they did nothing to close the party down.

According to a nearby resident, Mrs. Doug Welch, "The police told us it was a typical party. I can't believe it was a typical party. Kids were all over outside, in the house, in the streets. There was underage drinking. There was fighting. It was not typical." (AJ 4/18/83, AJC 4/24/83, AC 4/19/83, 4/21/83)

COURT RULINGS

COURT HOLDS PARENTS OF 20-YEAR-OLD LIABLE IN FATAL ACCIDENT

A California jury has ordered the parents of Bradley Nelson, 20, to join him in paying one million dollars in damages to the family of Gary Juhl, killed when Nelson's car struck Juhl's automobile.

In the landmark decision, the jury felt that even though Nelson was an adult at the time of the accident, his parents were liable "because they helped him buy and maintain the car, despite his long history of reckless driving and driving under the influence of liquor and drugs." (WP/UPI 4/17/83)

NEVADA COURT SAYS SELLER OF DRUGS CAN BE GUILTY OF MURDER IF PURCHASER DIES

A Nevada youth Timothy Slotemaker, 17, died from an overdose of sleeping pills in 1979. The Nevada Supreme Court has now ruled that a person who illegally sells drugs can be charged with second-degree murder if the buyer dies as a result of taking the drugs. Dana Lindsay Morris, who sold the pills to Slotemaker, can now be charged in the death. (WP 3/3/83)

DRUNK DRIVING

NEW YORK TEENS KILLED IN CRASH

Four New York teenagers were killed when the car in which they were riding hit a concrete retaining wall. The 18-year-old driver of the automobile, Michael McHugh, survived and has been charged with driving under the influence. Police stated the car was traveling at a very high rate of speed and that the crash ripped off the entire right side of the vehicle. (NYT 3/14/83)

L.S.D.

TEENS HIGH ON DRUGS INDICTED FOR MURDER OF STORE CLERK

Jimmy Tauses, a 24-year-old convenience [illegible] clerk, was killed in a robbery which netted the sum of $33 to his assailants. Two Atlanta teenagers, Hayden Hall, 19, and Mike Inman McCart, 17, were arrested and charged with the murder. McCart is the son of DeKalb County Police Major E. E. McCart.

Both of the accused told Fulton County Magistrate Edgar Gentry that they took "a considerable amount of drugs" on the night of the slaying. Police said they believed the boys had taken L.S.D. before they entered the store where Tauses was working. (AC 2/25/83, AJC 3/13/83)

SLAYING OF REPORTED DEVIL WORSHIPERS LINKED TO WINE AND L.S.D.

Seventeen-year-old Kenneth Avery Lowrance Brock pleaded guilty to the shooting deaths of Charles Scudder and his housekeeper Joseph Odum and was sentenced to three consecutive life-terms. The victims were reportedly "devil worshipers" who lived in seclusion in a castle-like home in the mountains of North Georgia. Scudder was formerly employed as a researcher and associate professor at Chicago's Loyola Institute of Mind, Drugs and Behavior.

Samuel T. West, 30, also charged with murder in the case, testified the shooting occurred after a wine-drinking party. West said he thought the wine was mixed with something else. His attorney contends the "something else" was L.S.D., which he says Scudder gave West and Brock in an experiment. Police found three vials labeled "LSD 25" in the house, but a judge ruled the vials could not be tested for L.S.D. (AC 12/22/82, AJ 2/16/83, AC/AP 3/7/83, AJ/AP 3/8/83)

METHADONE

METHADONE MIXTURE KILLS FOUR

Four people in Georgia and South Carolina thought they were buying cocaine. After using the drug, all of them died. Authorities analyzed the substance and found it to be a mixture of methadone and methamphetamines. (AC 3/7/83)

SURVEYS

ONE-FOURTH OF NEW YORK CITY'S HOMICIDES ARE DRUG-RELATED

In February, the New York City Police Department released a new study which shows nearly 25 percent of the city's homicides in 1981 were drug-related. Of the 1,832 homicides recorded for that year, 393 were drug-related. Police could not determine the circumstances surrounding some 176 of the murders.

"The use of drugs has become more extensive and pervasive, and when you have people selling drugs, you have guns, rivalries, rip-offs, and inevitably, violence," said James T. Sullivan, the chief of detectives. (NYT 2/18/83)

DRUGS AND EDUCATION

STUDENT INFORMANTS OFFERED CASH REWARDS

Students at suburban Dallas's Lewisville High School are being offered rewards of up to $100 for information leading to the arrest and subsequent conviction of fellow students who use and deal drugs. The school's Parent, Teacher and Student Association raised funds for this purpose. So far, $450 has been paid out. Thirty students have been reported to school authorities; 14 have been turned over to police.

Lewisville High School Principal Doug Killough, who brought the idea with him from Alabama, where he used to work, said, "Somebody had to do something, and this is working." (AC 4/11/83)

DOG USED TO DETECT DRUGS IN SCHOOLS

In Cobb County, a community north of Atlanta, Georgia, a drug-sniffing dog called "Sgt. Bandit" will be used to deter drug use in the county's 11 high schools. The dog will visit the schools first to give students a demonstration of his abilities. Afterwards he will make unannounced periodic visits to sniff lockers while students are away or to search school parking lots during school hours.

"The dog will be a useful adjunct to our undercover drug agents and our drug education program," said Tom Tocco, Cobb County School Superintendent. (AJ 2/28/83)

OLDER DRINKING AGE IS WORKING IN MARYLAND

On July 1, 1982, the legal drinking age of 21 went into effect in Maryland. Colleges across the state are reporting success in reducing drinking by underage students. Those who were 18 before July 1 are exempted from the new law. (WP/AP 2/22/83)

COLLEGES ASSESS STUDENT DRINKING; ENCOURAGE ALCOHOL CURBS

Colleges throughout the nation are expressing growing concern about alcohol consumption among students. Many states are raising the legal drinking age, and this has spurred increased efforts by campus administrators and student organizations to discourage drinking among underage students.

James E. Dull, Dean of Students at the Georgia Institute of Technology, says freshman surveys indicate a decrease in drinking by underage students since the state's drinking age was raised from 18 to 19 in 1980. The number of freshmen who drink alcohol at least twice a week dropped from 79 percent in 1980 to 63 percent in 1982.

"When the (drinking) age was 21, we had very few (disciplinary) problems connected with drinking, but we find now that people with these problems have grown in numbers," said Dull. He says 90 percent of students who have disciplinary problems also have problems with alcohol.

Jean Mayor, president of Tufts University in Massachusetts, says efforts to curb student drinking "reduced (the) level of vandalism, which at a school like ours is totally related to alcohol."

The University of Connecticut, Ohio Wesleyan and other institutions have banned drinking in public areas of dormitories. This past fall, Yale prohibited alcohol at any university-sponsored event primarily intended for freshmen and outlawed advertisements saying alcohol would be served at parties.

Many colleges are requiring new identification procedures for students. The University of California at Berkeley, where the minimum drinking age has been 21 for over 50 years, is tightening dormitory drinking privileges and prohibits the use of student fees for the purchase of alcohol.

National surveys say from 75 to 95 percent of college students drink alcohol. (NYT 3/8/83, AJ 2/10/83)

DRUGS AND ENTERTAINMENT

DANCE HALL RIOT RESULTS IN LOSS OF PERMITS

Following a riot by punk-rock fans, authorities in Huntington Park, California, withdrew the business, dance, entertainment and alcohol permits of the Mendiloa Ballroom. The riot caused some $25,000 in damages and unestimated theft losses to surrounding businesses. (NYT 2/14/83)

ROCK PERFORMERS BARRED FROM SUMMER CONCERTS

Park officials in Burbank, California, have banned some rock musicians from their lineup of performers because of the "rowdy crowds" the groups attract. Clash, Kiss, Toto and Bette Midler were singled out. Additional reasons cited were "Bette's bad mouth and alleged drug involvement by Toto's Robert Kimball." (See related story in the March 1983 issue of Drug Abuse Update: Toto's Robert Kimball Pleads Innocent.) (USAT 4/28/83)

WATT REVERSES BAN ON JULY 4TH BEACH BOYS CONCERT

Interior Secretary James Watt banned the Beach Boys from July 4th festivities on the mall in Washington, D.C. He said he was concerned the Beach Boys would attract a crowd of "drinking, drug-taking youths."

"We're not going to encourage drug abuse and alcoholism as was done in the past years...," said Watt.

However, following a meeting with President Reagan, Watt lifted his ban on rock performances at the event. "The president is a friend of the Beach Boys and he likes them, and I'm sure when I get to meet them I'll like them," Watt said following the meeting. (AJ/WP 4/6/83, AC/UPI 4/8/83)

DRUGS AND GOVERNMENT

MRS. REAGAN, KEEBLER COMPANY, DC COMICS TEAM UP TO FIGHT DRUG ABUSE

Fourth graders in 35,000 of the nation's schools are receiving a special issue of "The New Teen Titans," a comic book distributed by the U.S. Education Department. A colorful poster which accompanies the comic book echoes the Teen Titans theme: "We want you to be a hero...Stay drug free!"

A Weekly Reader survey of elementary school students revealed schools are not beginning drug education at an early enough grade level to counteract pressure to use drugs. According to the survey, peer pressure begins in fourth grade. The comic book is accompanied by a letter from Mrs. Reagan who urges children to stay away from drugs. "...Declare that you will stay drug-free. At any cost...And you'll be a hero...," says Mrs. Reagan.

The cost of the comic book was underwritten by the Keebler Company and produced by DC Comics of New York. (AC/AP 4/26/83)

DISTRICT OF COLUMBIA DRUG ABUSERS BUY DRUGS WITH MEDICAID

Hundreds of drug abusers in Washington, D.C., are using Medicaid to purchase large quantities of prescription drugs, according to a new report. The District of Columbia Department of Health and Human Services sponsored an audit of Medicaid records which reveals some 560 recipients received more than 65,000 prescriptions in one year's time, costing the program $730,862.

Investigators studied cases of anyone

who received more than 100 prescriptions in a year or who seemed to be using large amounts of drugs prone to abuse such as Valium, Darvocet and Percodan. (WP 3/2/83)

PRESIDENT'S DRUNK-DRIVING PANEL MAKES RECOMMENDATIONS

The President's Commission on Drunk Driving recommends that all states raise the minimum drinking age to 21 and tighten drunk-driving offenses by eliminating plea bargaining, requiring prompt suspension of licenses, and imposing uniform mandatory sentencing of "...either 48 hours in jail or 90 days suspension plus 100 hours of community service."

The Commission's chairman, former Massachusetts Governor John Volpe, presented the report to the Lifesavers II Conference attended by more than 600 delegates from nearly every state and many foreign countries.

President Reagan announced he would extend the Commission until the end of this year. (AJ/UPI 4/6/83)

REPRESENTATIVE DELLUMS DENIES DRUG ALLEGATIONS

California's Representative Ronald V. Dellums denies that he or any of his staff members have ever used or sold marijuana or cocaine. Dellums is under investigation by the House Committee on Standards of Official Conduct following a story in the Washington Post which said former House employee Robert Yesh told a Federal grand jury Dellums and some of his aids had sold or bought and used illegal drugs. (NYT/AP 3/17/83)

KENNEDY, EIGHT OTHER CONGRESSMEN IMPLICATED IN CAPITOL HILL DRUG INVESTIGATION

In what may have the makings of a cause celebre, columnist Jack Anderson publicly released the names of nine members and former members of Congress, including Senator Ted Kennedy (D-Massachussetts), who have been identified in testimony before a federal grand jury and the House Ethics Committee" as persons who 'may be using controlled substances purchased' through a Capitol Hill cocaine ring."

Others include former Representative Barry Goldwater, Jr. (R-California), Representative Ronald Dellums (D-California), Ex-Representative Fred Richmond (D-New York), Ex-Representative Lionel Van Deerlin (D-California), Representative Charles Wilson (D-Texas), Representative Gerry Studds (D-Massachusetts), Representative Parren Mitchell (D-Maryland), and Ex-Representative John Burton (D-California). All have heatedly denied the charges.

Anderson says he has known the names for over a year. It was he who discovered the dope ring. He arranged congressional cover for a narcotics agent who "...helped to break the narcotics ring, arrested the alleged ring leaders and seized a quarter-million dollars worth of cocaine." The suspected ringleaders, who fled to Australia, have now been extradited, but Anderson says it's uncertain whether they'll ever testify.

The Washington Post refused to carry Anderson's column. Joe Califano, who is in charge of the House investigation, said in his files he could find no evidence against Senator Kennedy. The Justice Department said its files revealed nothing that would involve the senator.

Anderson wrote a second column in which he defended his original piece and printed specifics which he said would help both Califano and the Justice Department locate the missing evidence in their files. (AJ 4/27/83, 5/11/83)

DRUGS AND INDUSTRY

NON-SMOKERS' MOTEL SUCCESSFUL IN TEXAS

Lyndon Sanders of Dallas, Texas, operates a non-smokers' motel at which none of the staff or customers smoke. He can run his 134-room inn for 30 percent less than a conventional motel because he does not have to repair or replace furniture and carpets due to cigarette burns.

Out of the 50,000 customers who have stayed at the Non-Smokers' Inn, only one has violated the no-smoking agreement. (AJ/UPI 3/30/83)

GENERAL MOTORS RESEARCHING IN-AUTO DRUNK DRIVING TEST

General Motors is researching practical use of a device for providing a sobriety test. The test, called the "Critical Tracking Task," was developed by the National Aeronautics and Space Administration.

The system, installed in the automobile, would test whether or not a driver is sober enough to perform driving skills. If the driver fails the test, the car will either not start, operate at very reduced speeds or set off an alarm system to warn other drivers and police officers. (AJC/UPI 3/12/83)

INSURANCE COMPANY JOINS POLICE IN DRUG PROBE

In conjunction with the Boston Police Drug Control Unit, representatives of Blue Cross-Blue Shield conducted a six-week investigation which resulted in the arrest of two men, one a former employee of Blue Cross-Blue Shield. Also resulting was the dismissal of 21 Blue Cross-Blue Shield employees who had apparently been observed buying, selling, distributing or using drugs during the investigation. Although no further charges have been filed, criminal complaints are being sought against those who were in the bar where the arrests took place.

One of the 21 employees fired felt that four or five of those dismissed were selling drugs during company time and perhaps 10 others had bought or used drugs, but that the others were victims of circumstance. (BG 2/25/83)

DRUGS AND KIDS

CHILDREN TESTIFY BEFORE HOUSE SELECT COMMITTEE

The new House Select Committee on Children, Youth and Families heard testimony from eighty 10-, 11- and 12-year-old children concerning their fears about economic troubles, nuclear war, crime in the streets and drug pushers in their schools.

"If streets, schools and homes are unsafe, where can we go? Does our world have to be like this?" asked Maura Coniff, 12, of South Plainfield, New Jersey. "Can't you please change it?" (WP 4/29/83)

SMOKING "OUT" AMONG TEENS

The University of Michigan annual High School Senior Survey finds that smoking is no longer deemed "cool" by the class of 1982. Daily smoking by seniors dropped 8 percent between 1977 and 1982, chiefly because of health concerns which students feel are not exaggerated.

Young people don't buy the tobacco industry's advertising images that smokers are rugged he-men or liberated women. Two-thirds of those surveyed prefer to date non-smokers. Almost 60 percent feel smoking reflects poor judgment. (AC/UPI 2/22/83)

DRUGS AND LAW

POLICE VIDEOTAPE D.U.I ARRESTS FOR COURT USE

Police in Cobb County, Georgia will start videotaping arrests of suspected drunk drivers because they say juries often have difficulty believing the clean-cut defendant who appears in court is the "staggering, bellicose drunk" the arresting officer describes. State Court Judge Michael Stoddard of Cobb County says he doesn't think there will be any problem admitting the videotapes as evidence in court. (AJ 2/23/83)

AUSTRALIA'S TOUGH NEW LAW KEEPS DRUNKS OFF ROADS

In New South Wales, Australia's largest state, any driver whose blood alcohol level is above .05 is subject to arrest. The new law went into effect in December, and traffic fatalities from December 17 to January 26, 1982, dropped to 87, compared with 179 for the same period of the previous year.

Australia ranks third behind Czechoslovakia and West Germany in beer sales. When the new law went into effect, however, beer sales dropped 40 percent in some establishments in New South Wales.

The .05 blood alcohol level is stricter than the toughest law anywhere in the United States. Idaho and Utah use a figure of .08, but elsewhere in the nation the legal intoxication limit is .10. (USAT 2/17/83)

BREATH-TESTING MACHINES FOR TAVERNS SUGGESTED

A commissioner from DeKalb County, Georgia, has suggested that all taverns be required to have breath-analyzer machines. The machines would allow customers to check their physical condition before driving. (DNS 2/16/83)

INGREDIENTS MUST BE LISTED ON LIQUOR CONTAINERS

U.S. District Court Judge John H. Pratt has ordered the Treasury Department to require beer, wine and liquor manufacturers either to list ingredients on beverage containers or to print an address where people can write for the contents. Pratt says medical researchers have found evidence that some ingredients in alcoholic beverages could cause adverse reactions in some people. (WP 2/10/83)

ANTI-DRUNK DRIVING EFFORTS CUT TRAFFIC DEATHS IN SOME STATES

In 1982, seven states and the District of Columbia showed a drop of over 20 percent in fatal automobile accidents while total auto fatalities for the nation as a whole decreased by 5,227 deaths.

Tough new driving-under-the-influence legislation and other anti-drunk driving campaigns are credited with this reduction. (USAT 2/24/83)

REFUSAL TO TAKE DRUNK-DRIVING TEST CAN BE USED AS EVIDENCE IN COURT

In a 7 to 2 decision, the United States Supreme Court ruled that a motorist's refusal to take a blood alcohol test can be used as evidence against him in court proceedings.

Justice Sandra D. O'Connor, who wrote the opinion, held that because the blood test is not a form of police interrogation, authorities do not have to warn suspects that refusal to take the test will be used against them. The ruling is expected to be a boost to the nationwide crackdown on drunk driving. (WP 2/23/82)

ARIZONA TO CONSIDER TAXING ILLICIT DRUGS

Arizona is considering a bill that would impose a luxury tax on confiscated illicit drugs: $10 an ounce on marijuana and $125 an ounce on cocaine, heroin, and other drugs. If an arrested drug dealer could not pay the tax, the state could then seize his tangible assets.

A provision in the bill provides drug dealers and smugglers with an out: to avoid paying the tax, they could purchase a luxury tax license from the state's revenue department. While this would mean smugglers in effect would be reporting their illegal activity to authorities, it would also virtually make them immune from investigation because the revenue department would be prohibited from turning the information over to law enforcement officials.

State Senator Jeff Hill, who introduced the bill, predicted that Arizona would have increased its revenues by some $10 million had the law been in effect in 1982. (WP 2/26/83)

NEW YORK MAY EXPAND FORFEITURE LAW

New York is considering an expanded forfeiture law which would allow the state to seize personal assets of criminals. Funds raised would be used to reimburse victims and to help pay for prosecutions and investigations. (NYT 3/25/83)

DRUGS AND SMUGGLING

HOSPITAL EMPLOYEES FIRED AFTER DRUG INVESTIGATION

After officials at Atlanta, Georgia's, Crawford Long Hospital received a tip that non-professional personnel were using or dealing drugs on the job, police began an undercover investigation. As a result, 16 employees have been fired and two of those arrested. (AJ 3/15/83)

LAUNDERING OF DRUG MONEY INCREASES IN GEORGIA

Because of the government's crackdown on drug smuggling in Florida, smugglers have moved north into Georgia. "Between 1976 and 1980, Georgia banks handled 4,731 cash transactions of $10,000 or more...." But in 1981 alone, they handled 3,750 such transactions.

Both convicted drug smugglers and state authorities report extensive real estate transactions are taking place with drug money.

Tully Miller, district director of the Internal Revenue Service in Atlanta, says investigations of high-level drug dealers who have moved into the state account for about 40 percent of the work load of IRS's Atlanta criminal investigations section.

"With Georgia becoming the focal point of their (drug smugglers') smuggling and distribution activities," says U.S. Attorney Larry Thompson, "this state is becoming the starting point in the chain that they have to go through in disposing of and laundering huge amounts of cash." (AJC 4/3/83)

$24 MILLION IN OPIUM SEIZED

After a Chicago undercover agent made a down payment on some opium, his fellow officers moved in, confiscating $24 million worth of the tar-like substance and arresting three men. Narcotics division Commander Lawrence Forberg said the bust was probably Chicago's largest opium arrest in history. (AC 2/28/83)

"CHURCH" LEADER ARRESTED FOR POT SALES

New York police arrested Mickey Cezar and charged him with selling marijuana. Cezar was head of a door-to-door marijuana delivery service which claimed to be a church called the "Church of the Realized Fantasies." The organization reportedly sold as much as $30,000 worth of marijuana daily. (AC/UPI 3/25/83)

SUBWAY CRACKDOWN IN NEW YORK RESULTS IN NUMEROUS SUMMONSES FOR SMOKING

A six-member uniformed squad was formed to patrol New York's subways, looking for violators of the no-smoking rule on both trains and platforms. During a one-month period, 2,143 summonses were issued. Some one-third of those were for marijuana smoking. Violators face fines of up to $100. (NYT 4/29/83)

PYTHONS AND VIPERS GUARD POT STASH

Snake handlers from the U.S. Fish and Wildlife Service were standing by as Customs agents at Kennedy Airport in New York removed 89 African pythons, gaboon vipers and rhinocerous vipers from crates containing some $10,000 worth of marijuana. When two men from the Reptile Traders of Freeport tried to claim the crates, they were arrested on charges of possession with intent to distribute. If convicted, they face 15-year prison terms. (AC/AP 3/17/83)

$200 OFFERED BY "MARIJUANA BUSINESSMAN" IN EXCHANGE FOR A VOTE

A "marijuana businessman" sent anonymous letters and $200 checks to eight Virginia senators urging them to vote for a bill to raise the state's beer-drinking age to 21.

The letter said, "Marijuana is illegal, cannot be advertised and cannot be distributed easily. Beer, on the other hand is legal... With the new 21 (year-old) law, marijuana businessmen will be able to compete fairly in a major market."

None of the senators interviewed said their vote would be influenced by the appeal, nor did any intend to cash the checks. (WP 2/8/83)

PARK POLICE SAY DRUG USE WIDESPREAD IN DISTRICT OF COLUMBIA PARKS

Frustrated by budget cuts and manpower shortages, ten U.S. Park Police officers sought help from U.S. Representative Stan Parris (R-Virginia). Parris is a member of the Select Committee on Narcotics and Drug Abuse. "There is widespread drug dealing in the federal parks (in the Washington area)...," the officers told Parris. They said escalating drug traffic is contributing to the increase in rapes, assaults and drug-overdose deaths taking place in Washington-area federal parks.

The officers say they can't control trafficking in the parks because they don't have enough manpower. In the past three years, 58 positions have been dropped. The unit's narcotics task force was abolished after it made several drug arrests.

Rep. Parris asked for a meeting with Interior Secretary James Watt to discuss the charges. (WP 4/26/83)

DRUGS AND SPORTS

L.S.U. WON'T SELL BEER AT GAMES

The Louisiana State University Board of Supervisors voted against a proposal to allow beer to be sold on an experimental basis during two football games and several spring baseball games. Athletic Director Bob Bordhead said that the University could have made $300,000 a year from the sale of beer.

The National Collegiate Athletic Association has no policy forbidding the sale of alcohol at athletic events, but L.S.U. currently does not allow any intoxicating beverages at such competitions. (AJC 4/16/83)

FORMER ATLANTA FALCON DELIVERS ANTI-DRUG MESSAGES TO KIDS

Tony Plummer's use of cocaine began while he played pro-football with the Atlanta Falcons. After his athletic career ended, he supported his $1,000-a-week cocaine habit by using the money he had earned as a player.

In 1982, when the money ran out, he began selling cocaine. Plummer was arrested and jailed in DeKalb County, Georgia, after selling cocaine to undercover agents. While awaiting trial, he broke his psychological addiction to cocaine. He pleaded guilty to selling cocaine and was given a suspended sentence. Given a second chance, Plummer decided to work with young people to steer them away from drugs before they start and now gives talks to local schools. (AJC 2/10/83)

TENNIS PRO CLEARED IN DRUG INVESTIGATION

The March 1983 issue of Drug Abuse Update carried a story from the New York Times implicating tennis player Vitas Gerulaitis in a cocaine conspiracy. (See World's Fifth-Ranked Tennis Player a Suspect in Cocaine Deal.)

After a year-long investigation, U.S. Attorney John S. Martin, Jr. says Gerulaitis is cleared of the charges. (WP/AP 3/23/83)

NEW PUBLICATIONS

BIBLIOGRAPHIES

The National Clearinghouse for Drug Abuse Information, a division of the National Institute on Drug Abuse, will send free of charge its bi-monthly bibliography of new publications. Single copies may be ordered free. Write to: NCDAI, P.O. Box 416, Kensington, MD 20795.

BOOKS

DRUGS AND DRUG ABUSE: A REFERENCE TEXT, by Terrance C. Cox, MA; Michael R. Jacobs, Ph.D; A. Eugene LeBlanc, Ph.D; and Joan A. Marshman, Ph.D; is a 600-page book which contains complete monographs on 64 most-used drugs and shorter essays on 23 others. The drugs are cross-indexed by medical/scientific terms, trade names and street names. Addiction Research Foundation, Toronto, 1983, $29.50. Order from: Marketing Services, Department MJ, Addiction Research Foundation, 33 Russell Street, Toronto, Canada M5S 2S1.

A CRY FOR HELP: EXPLORING AND EXPLODING THE MYTHS ABOUT TEENAGE SUICIDE — A GUIDE FOR ALL PARENTS OF ADOLESCENTS by Mary Griffin, M.D. and Carol Felsenthal, discusses reasons for the sharp rise in the suicide rate of youth, cites statistics and gives guidance in dealing with the problem to parents, professionals and others who work with young people. Doubleday, New York, 1983, $16.95.

PAMPHLETS

Health Communications, Inc., has a series of pamphlets giving information about various types of drugs. A sampler kit (one of each) costs $2.50; single copies are 25¢ each. Pamphlets about the following drugs are available: **HALLUCINOGENS, COCAINE, MARIJUANA, QUAALUDES, P.C.P., HEROIN, ALCOHOL, TOBACCO, STIMULANTS, DEPRESSANTS, TRANQUILIZERS, SOLVENTS/INHALANTS.**

Order from: Health Communications, Inc., 2119-A Hollywood Boulevard, Hollywood, FL 33020.

1982 INDEX NOW AVAILABLE

The editors of Drug Abuse Update have prepared an index of all issues (Numbers 1 through 3) published in 1982. The index lists alphabetically the titles of all articles published under each category during the 1982 year and gives the page number and issue date in which each article appears.

The index is especially useful for subscribers who are collecting or binding a full year's set of Drug Abuse Updates. To order, send $3.00 to: Index, Drug Abuse Update, Families in Action, Inc., Suite 300, 3845 N. Druid Hills Road, Decatur GA 30033.

Proceeds from the sale of Families in Action publications help fund the organization.

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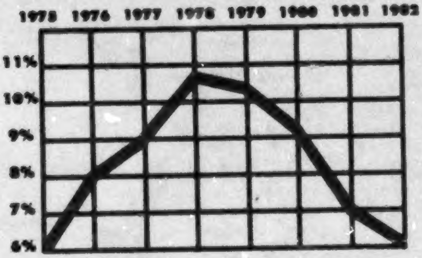

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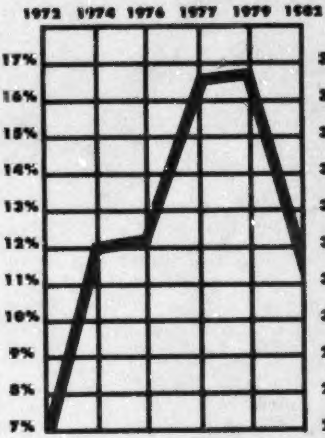

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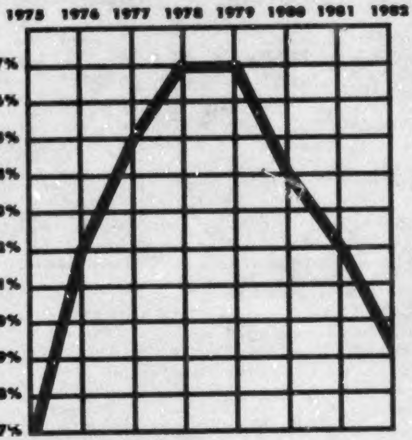

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■ After Parents' Drug Prevention Movement Began

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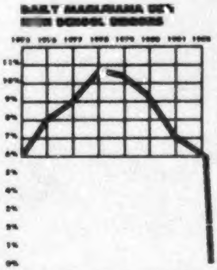
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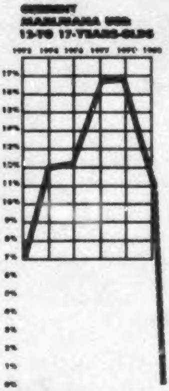
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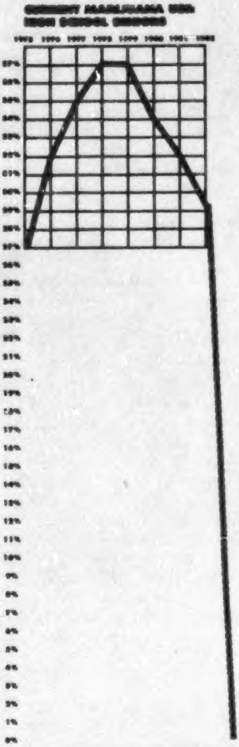
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2. We came to believe that a power greater than ourselves could restore us to sanity.

3. We made a decision to turn our will and our lives over to the care of God as we understood Him.

4. We made a searching and fearless moral inventory of ourselves.

5. We admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

6. We were entirely ready to have God remove all these defects of character.

7. We humbly asked Him to remove our shortcomings.

8. We made a list of all persons we had harmed, and became willing to make amends to them all.

9. We made direct amends to such people wherever possible, except when to do so would inure them or others.

10. We continued to take personal inventory, and when we were wrong promptly admitted it.

11. We sought through prayer and meditation to improve our conscious contact with God, as we understood Him, praying only for knowledge of His will for us, and the power to carry that out.

12. Having had a spiritual awakening as a result of those steps, we tried to carry this message to addicts and to practice these principles in all our affairs.

THE TWELVE TRADITIONS OF NARCOTICS ANONYMOUS

We keep what we have only with vigilance and just as freedom for the individual comes from The Twelve Steps, so freedom for the groups springs from our traditions.

As long as the ties that bind us together are stronger than those that would tear us apart, all will be well.

1. Our common welfare should come first; personal recovery depends on N.A. unity.

2. For our Group purpose there is but one ultimate authority—a loving God as He may express Himself in our Group consicence, our leaders are but trusted servants, they do not govern.

3. The only requirement for membership is a desire to stop using.

4. Each Group should be autonomous, except in matters affecting other Groups, or N.A., as a whole.

5. Each Group has but one primary purpose—to carry the message to the addict who still suffers.

6. An N.A. Group ought never endorse, finance, or lend the N.A. name to any related facility or outside enterprise, lest problems of money, property or prestige divert us from our primary purpose.

7. Every N.A. Group ought to be fully self-supporting declining outside contributions.

8. Narcotics Anonymous should remain forever nonprofessional, but our Service Centers may employ special workers.

9. N.A., as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.

10. N.A. has no opinion on outside issues; hence the N.A. name ought never be drawn into public controversy.

11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, and films.

12. Anonymity is the spiritual foundation of all our Traditions, ever reminding us to place principles before personalities.

The Twelve Traditions of N.A. are not suggested, and they are not negotiable. These are the rules that keep our fellowship alive and free.

By following these principles in our dealings with others in N.A. and society at large, we avoid many problems. That isn't to say that our traditions eliminate all problems. We still have to face difficulties as they arise: Communication problems, differences of opinion, internal controversies, problems with individuals, groups outside the fellowship. However, when we apply these principles we avoid some of the pitfalls.

Simplicity is the keynote of our symbol; it follows the simplicity of our fellowship. We could find all sorts of occult and esoteric connotations in the simple outlines, but foremost in our minds were easily understood meanings and relationships.

The outer circle denotes a universal and total program that has room within for all manifestations of the recovering and wholly recovered person.

The square, whose lines are defined, is easily seen and understood; but there are other unseen parts of the symbol. The square base denotes Goodwill, the ground of both the fellowship and the member of our society. Actually, it is the four pyramid sides which rise from this base in a three dimensional figure that are the Self, Society, Service and God. All rise to the point of Freedom.

All parts thus far are closely related to the needs and aims of the addict seeking recovery and the purpose of the fellowship seeking to make recovery available to all. The greater the base, as we grow in unity in numbers and in fellowship, the broader the sides and the higher the point of freedom. Probably the last to be lost to freedom will be stigma of being an addict. Goodwill is best exemplified in service and proper service is "Doing the right thing for the right reason." When this supports and motivates both the individual and the fellowship, we are fully whole and wholly free.

MISCONCEPTIONS

THERE ARE MANY MISCONCEPTIONS ABOUT N.A. SO WE WISH TO STATE WHAT N.A. DOES NOT DO

1. *N.A. does not,* operate detox units, recovery or half way houses and is not affiliated with such facilities; we do, however, cooperate with those who cooperate with us.
2. *N.A. does not,* crusade, solicit, advertise for members or try to persuade anyone to join us.
3. *N.A. does not,* engage in or sponsor research.
4. *N.A. does not,* Keep membership records or case histories, nor follow-up on members or in any way try to control them.
5. *N.A. does not,* make medical or psychological diagnoses or prognoses nor provide marriage, family or vocational counselling.
6. *N.A. does not,* provide walfare or other social services.
7. *N.A. does not,* conduct spiritual or religious services of any kind.
8. *N.A. does not,* engage in education or propaganda about drugs.
9. *N.A. does not,* accept money for its services, is not funded by any public or private sources or agencies. Accepts no contributions from non-N.A. sources.

NARCOTICS ANONYMOUS GROUP REGISTRATION FORM

The purpose of this form is to establish or maintain the link between your group and the rest of N.A. We need the following information in order to list your group in the World Directory, send you new materials; such as, new literature, forthcoming newsletters and general correspondence. We also need this so that we may refer newcomers and new groups in your general area to your G.S.O. PLEASE FILL OUT AND RETURN TO US AT –

N.A. World Service Office, Inc.
P.O. Box 622
Sun Valley, CA 91352

Today's Date ____________ City ____________ State ____________

☐ Add us to WORLD DIRECTORY
☐ We're starting a new group; please send STARTER KIT
☐ There have been some changes; the following is updated information, please correct your records.

Meeting Day ____________ Time ____________ ☐ A.M. ☐ P.M.

Type of Meeting ____________ ☐ Open ☐ Closed

Location of Meeting ____________

Street ____________

City ____________ State ____________ Zip ____________

Mailing Address: Name ____________

Street ____________

City ____________ State ____________ Zip ____________

Secretary ____________ Phone (   ) ____________

Treasurer ____________ Phone (   ) ____________

G. S. R. ____________ Phone (   ) ____________

If your Group has any special needs, problems or questions, use the reverse side of this form to communicate them to the World Service Office.